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ASSESSMENT REPORT

SPECIAL OBJECTIVE: RAPID INCREASE OF HIV/AIDS PREVENTED

(Formerly AIDS SURVEILLANCE AND EDUCATION PROJECT)

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EXECUTIVE SUMMARY

The AIDS Surveillance and Education Project (ASEP) assists the Department of Health, local governments and NGOs to implement STD/HIV/AIDS surveillance, prevention and control programs. With USAID's re-engineering of program management systems, ASEP became the principal activity under USAID's Special Objective: Rapid increase in HIV/AIDS prevented.

Surveillance activities include HIV Sentinel Surveillance (HSS) and the Behavioral Surveillance Survey (BSS). Education activities consist principally of local government and NGO IEC programs for prevention and control of STD/HIV infection. Both components concentrate primarily on six high-risk behavioral "groups": registered female commercial sex workers (FCSW), freelance CSWs (FLCSW), male CSWs, men who have sex with men (MSM), injecting drug users (IDU) and male STD patients.

This Assessment was conducted as ASEP approaches its planned completion date - September 30, 1997. **The overall recommendation of this Assessment is to extend ASEP activities for three additional years until September 30, 2000, and to increase funding for LGU/NGO education programs, identification of local financing mechanisms for STD/HIV-related activities and policy analysis and advocacy.**

- SURVEILLANCE

- Findings

HIV prevalence is generally low (<1 percent) in almost all of the targeted HSS high risk "groups"; the rate of new infections is not increasing rapidly. In other words, there has been no "explosion" of infections thus far in the Philippines. However, data indicate that high-risk behaviors are widespread among those groups where the potential for STD/HIV infection is greatest. While the HSS has clarified current STD/HIV prevalence, the system needs to address several persistent problems: these include: a) inadequate coverage/numbers of high risk "group" individuals for testing; b) inclusion of too many risk "groups" per round; c) unnecessary expansion of the HSS to too many sites/cities; and d) lack of a uniform behavioral surveillance questionnaire used by DOH for HSS and NGOs for their behavioral monitoring surveys.

- Recommendations

1. At the present time, a total of 6 to 8 cities is adequate to monitor HIV prevalence trends in the Philippines.
2. Only three risk "groups" (MSM, FCSWs, and IDUs) are needed in the largest cities (Manila and Cebu). In all of the other cities, only FCSWs should be routinely selected for HSS. If epidemiological studies indicate that the number of MSM and/or IDUs are relatively large in other sites (i.e., a few thousand), then these risk "groups" should be included.

3. HSS rounds can be carried out annually in all of the sites except for Angeles City and Cebu, where bi-annual rounds should be maintained.
4. The HSS sample size for the Philippines should remain at about 200-300 per group. The allotted time period of blood collection could be extended to reach this number. If 100 or less can only be collected, then this group should be omitted from the HSS rounds. Alternative survey methods using NGOs should be attempted if it is believed that there may be at least several thousand persons engaged in this risk behavior in this HSS site.
5. The HSS sample collection period can be extended to 3-4 months if needed.
6. All HSS sites do not have to be carried out during the same calendar time.
7. Use of the “saliva” test for HSS should be explored for those risk groups who are reluctant to have their blood drawn.
8. The DOH must add a question on condom usage to the HSS and BSS that will obtain the same data that are currently collected by the NGOs.
9. Both the NGO and DOH questionnaires should collect information on condom usage for the last commercial sex partner, as well as condom usage with the last sexual encounter with a spouse, boy friend, or “steady/regular” partner.
10. Within three months of receipt of this report, the DOH should: a) complete an implementation plan for the nine preceding recommendations with which they agree, and/or b) provide a written response for those recommendations that it does not agree with or believes cannot be implemented.

-EDUCATION

- Findings

In general, PATH and the implementing NGOs have done an excellent job in developing new institutional capacities to reach high-risk individuals about STD/HIV/AIDS prevention.

Targeting: Current primary target groups continue to be at highest risk of infection, while the current risk of HIV infection to the general population remains low. There is a strong geographic targeting by NGOs.

IEC Theory and Strategy: NGOs are primarily using a health education approach implemented by peer educators. Interpersonal counseling techniques have not been extensively used due to limits in capacity of PATH to provide ongoing training and monitoring. Psychological, social, and environmental correlates of risk are not routinely addressed by the implementing NGOs. Low risk perception among target groups due to lack of direct evidence of HIV infections makes achieving risk reduction difficult. Lack of data on attitudes and perceptions among high-risk “groups” complicate identifying appropriate behavior change methods.

IEC Media: Knowledge about HIV infection routes and means of protection among the general and high-risk populations has been increased by IEC efforts. National HIV/STD PSAs of high quality have been aired on television. Sexually graphic IEC materials are suppressed due to concerns of religious groups, and IEC materials must be cleared by a censor board. Most IEC small media focus on biological issues related to HIV, many lack illustrations, and most do not address psychological and social correlates of risk behavior. Graphic photos of STD lesions have been used as IEC materials in many locations (many not associated with ASEP). People living with AIDS (PWA) are sometime depicted with scars and lesions.

Evaluation: Evaluation of NGO programs is conducted bi-annually through NGO administered surveys of risk behavior among a convenience sample of their target groups. Monitoring is conducted by PATH's Manila-based team, which has been constrained due to its limited staff size, i.e., there is no full-time monitoring professional.

Child Sex Workers: Very young girls working in the sex industry, especially as unregistered sex workers, are a growing problem; actual numbers of child sex workers are unknown. The prevention approach used by the NGO's is probably inappropriate for young girls.

Policy Issues: Environmental and policy barriers thwart risk reduction among the ASEP target groups, including: poor access to STD treatment, sex establishment managers who discourage condom use, no public health monitoring of sex establishments for condom use, failure of the legal system to suppress child sex work, and inadequate financial support for STD/HIV prevention.

Miscellaneous Issues: Training of health care workers in syndromic management of STDs has been positive; however, the widespread lack of STD drugs hinders successful STD control. Antibiotic resistance of STDs is a serious and growing problem. Condom social marketing to high-risk "groups" by DKT has been successful at making affordable condoms available to hard to reach "groups".

- Recommendations

1. Targeting: Targeting of CSWs, MSM, IDU, and other men at risk should be continued. Additional target groups that should be added include: a) child sex workers (age less than 16), b) sex establishment managers, drug suppliers, and Social Hygiene Clinic personnel, and c) local government policy makers.

2. IEC Theory and Strategy: Continue emphasis on peer education. Increase attention to personalized counseling with the CHOWs and PEs and monitor to assure this is happening. Provide training on interpersonal counseling. Address structural and environmental factors associated with risk behavior.

3. IEC Media: Small media should: a) include lower literacy materials, graphics, and stories; b) be targeted to specific groups; c) give attention to social, psychological, and environmental factors; and d) link STD experiences to HIV risk. Produce more copies of IEC materials. Avoid use of IEC materials depicting STD lesions, and people living with HIV (PWHIV) and PWA with scars and lesions. Mass media should be limited to PSAs which address: a) fear and stigma of PWHIV and PWA, b) social norms regarding sexual risk behavior and child sex work, and c) the linkage between STD symptoms and HIV risk.

4. Evaluation: Add outcome indicators on psychological correlates of risk. Coordinate outcome measures with the BSS. Evaluate programs on an annual basis. Use surveillance findings more effectively for planning NGO program activities. Use local independent institutions for evaluation when possible.

5. Child Sex Workers: Identify the extent and location of child sex work (CSWs less than age 16) and the factors that are promoting child sex work. Develop a specialized prevention strategy for child sex workers and incorporate this strategy into all program targeted on CSWs. Conduct training on the strategy with all NGOs working with CSWs.

6. Policy Issues: Develop a policy capacity to: a) conduct research and analysis of key issues, b) develop and deliver policy presentations to advocate for policy changes, and c) assist NGOs to conduct policy advocacy. Key policy issues are specified in the Section 3.6.

7. Miscellaneous: Continue training health care providers in syndromic management of STDs. Study antibiotic resistance of STDs. Continue support for DKT's social marketing of condoms to high-risk "groups".

- ORGANIZATIONAL ISSUES

- Findings

Though the PNAC continues to be a weak body, it recently produced the Philippine National HIV/AIDS Strategic Plan and has succeeded in requesting for secretariat support from the UNDP. Institutionalizing the STD/HIV/AIDS Unit within the DOH is reportedly part of the DOH reorganization bill currently under development that will be submitted to the legislature in April 1997.

The Local Government Code mandates LGUs to deliver health services, provides additional national budget allocations to the local level, and expands local taxing authorities (with local retention of revenues). However, local government budgets are as strained as national budgets and, after some three years of implementation, devolution remains an evolving process.

New linkages between the DOH and the LGUs are being developed; these include the Comprehensive Health Care Agreements (CHCAs) and DOH Regional representation on LGU health boards. How effective these mechanisms are remains to be determined.

ASEP has produced working models of LGU-NGO collaboration in STD/HIV/AIDS control and prevention in Quezon City, General Santos City, and Cebu City. Coordination between the education and surveillance components of ASEP remains weak. By February 15, 1997, the last activity funded by USAID to support the strategic and implementation plan of the National Voluntary Blood Services Program (NVPBSP) will be completed. The STD/HIV/AIDS Unit started to hold regular donor community meetings in the last semester of 1996.

- Recommendations

1. Future ASEP assistance should focus on the local level since LGUs are now responsible for delivering health care services and have the financial autonomy and governance to do so.
2. The existing LGU/NGO networks in STD/HIV/AIDS control and prevention developed with ASEP assistance should be used as models for other LGUs.
3. The project should extend technical assistance to selected LGUs for: a) creation of LGU/NGO networks that are eventually institutionalized, b) financial sustainability measures, c) development of implementing guidelines for the Sanitary Code, d) creation of public/private partnerships, and e) capacity building of NGOs and LGUs.
4. The ASEP Steering Committee should be reactivated for better coordination of surveillance and education activities with active involvement of the STD/HIV/AIDS Unit
5. ASEP should not fund NVBSP implementation.
6. The DOH should encourage active participation in quarterly donor coordination meetings.

- FINANCIAL SUSTAINABILITY

- Findings

It is unclear how current surveillance and education activities will be sustained after USAID assistance ceases. National and/or local governments are unlikely to allocate adequate funding for these activities from their existing budgets. Because of limited government resources and higher priority demands for funding, STD/HIV activities might, at best, receive modest funding. Spending on STD/HIV activities at the expense of other more popular programs, such as schools and roads, can be politically hazardous for elected officials.

Identifying new revenue sources to fund these activities is necessary. Several cities and NGOs have begun to experiment with generating revenues to cover STD/HIV-related activities. This includes charging a modest fee to attend seminars and workshops, selling condoms, using association membership fees for a semi-insurance health program, and collecting an annual head-tax on “entertainers”. Imposing an “entertainment” license on sexually-oriented establishments and retaining these funds for STD/HIV services and programs needs to be explored.

- Recommendations

ASEP should fund technical assistance to develop and disseminate financing mechanisms for STD/HIV activities by local governments and NGOs. The feasibility of incorporating this assistance into the PATH Cooperative Agreement should be explored.

- MANAGEMENT ARRANGEMENTS

- Findings

1. PATH Cooperative Agreement: Overall, PATH has done an extremely sound job with a difficult task. PATH has consistently fielded high caliber professional staff who have worked very effectively with their various counterparts, particularly at the local government and NGO levels. PATH has been highly responsive to new tasks added through amendments to the CA. Greater attention needs to be given to improving the utility of NGO program monitoring, coordinating it with FETP's BSS.

2. The WHO Surveillance Grant: WHO provided effective administrative support up through 1995. Technical assistance for implementing the HSS was provided by a resident U.S. CDC Epidemiology advisor funded by USAID and external experts on short-term basis. Since the end of the GPA/WHO in December 1995, WHO is hard pressed to continue its past level of support. WHO's proposal to contract for an advisor for technical and administrative support using ASEP grant funds needs to be re-considered in light of the Assessment's recommendations on surveillance.

3. USAID's Results Framework for the HIV/AIDS Special Objective:

Based on the recommendations of the Assessment, USAID/Philippines will need to revise its indicators at the Special Objective, Intermediate Results and Activity levels. As currently stated, the Intermediate Result (IR) focuses solely on behavioral changes to measure progress. USAID needs to consider expanding the IR to include knowledge and attitudinal changes as intermediate or precursor steps to achieving widespread behavioral change.

- Recommendations

1. PATH's CA should be extended to September 30, 2000 with additional funding to support LGU/NGO education programs. USAID should determine whether recommended assistance for financing mechanisms and policy work should be included in PATH's CA; alternative approaches should be considered as well, i.e., the new cooperative agreement for the Global Bureau's HIV/AIDS Strategic Objective.

2. Based on the Assessment's recommendations, administrative and technical support from WHO needs to be reconsidered. First, a multi-year workplan needs to be developed which accommodates planned activities to fit the balance of funds remaining in the WHO grant. No additional funds should be committed to surveillance unless the detailed workplan indicates funding shortages in FY 1999 or FY 2000. Technical guidance for the HSS and the BSS should be obtained from external experts on a short-term basis.

3. USAID needs to revise and re-negotiate its Results Framework for the HIV/AIDS Special Objective with the DOH and other partners.

ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ASEP	-	AIDS Surveillance and Education Project
AusAID	-	Australian Agency for International Development
BRL	-	Bureau for Research and Laboratories
BSS	-	Behavioral Surveillance Survey
CDC	-	U.S. Centers for Disease Control
CHCA	-	Comprehensive Health Care Agreement
CHOW	-	Community Health Outreach Worker
COMDEV	-	Community Health and Development, Inc.
CRECHE	-	Crying Room and Extra Caring Hand for Education
CSW	-	Commercial Sex Worker
DOH	-	Department of Health
EC	-	European Community
EU	-	European Union
FCSW	-	Female (registered) Commercial Sex Worker
FETP	-	Field Epidemiology Training Program
FLCSW	-	Free lance (female) Commercial Sex Worker
FORGE	-	Fellowship For Organizing Endeavors
Free LAVA	-	Free Legal Assistance Volunteers Association
GC	-	<i>Neisseria gonorrhea</i>
GPA	-	Global Program for AIDS
HMDTS	-	Health Manpower Development Training Service
HIV	-	Human Immunodeficiency Virus
HSS	-	HIV Sentinel Surveillance System
IDU	-	Injecting Drug User
IEC	-	Information, Education and Communication
JICA	-	Japanese International Cooperation Agency
KAP	-	Knowledge, Attitude and Practice
KfW	-	Kreditanstalt fur Wiederaufbau
LGU	-	Local Government Unit
MSM	-	Men who have Sex with Men
NAAC	-	National AIDS Advisory Committee
NAPCP	-	National AIDS Prevention and Control Program
NASPCP	-	National AIDS/STD Prevention and Control Program
NGO	-	Non-governmental Organization
NTMF	-	New Tropical Medicine Foundation
NVBSP	-	National Voluntary Blood Services Program
OHFSR	-	Office of Hospitals, Facilities, Standards and Regulation
OPHN	-	Office of Population, Health and Nutrition
PATH	-	Program for Appropriate Technology in Health
PE	-	Peer Educator
PIHES	-	Public Information and Health Education Service
PNAC	-	Philippines National AIDS Council
PSA	-	Public Service Announcement
PWA	-	Person living with AIDS
PWHIV	-	Person living with HIV
RITM	-	Research Institute for Tropical Medicine

SEAMEO-TROPMED	-	Southeast Asia
SHC	-	Social Hygiene Clinic
STD	-	Sexually Transmitted Disease
TWG	-	Technical Working Group
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Fund for Population Activities
UNICEF	-	United Nations Children Fund
USAID	-	United States Agency for International Development
USPF	-	University of Southern Philippines Foundation
WHO	-	The World Health Organization

SECTION 1: THE AIDS SURVEILLANCE AND EDUCATION PROJECT

1.1 Purpose of the Assessment

The AIDS Surveillance and Education Project (ASEP) was designed in early 1992 to support the Department of Health (DOH) of the Philippines to develop and implement its National AIDS/STD Prevention and Control Program (NASPCP). To control HIV transmission, ASEP supports institutionalizing public and private sector mechanisms needed to monitor HIV prevalence and to encourage behaviors which reduce individual risk for contracting and transmitting HIV. With the re-engineering of USAID programs and management systems, ASEP became the principal activity in support of USAID/Philippines' Special Objective: Rapid Increase of HIV/AIDS Prevented. At present, ASEP's total budget is \$10.8 million, making USAID the largest donor contributor to the DOH's NASPCP.

Implementation of ASEP activities - principally HIV surveillance, and local information, education and communication programs - commenced in 1993. The number of sites (cities) for these activities have expanded gradually over the past three years. ASEP's assistance is currently scheduled for completion by September 30, 1997. However, the need to continue ASEP's assistance is apparent to both USAID and the DOH. The purpose of this assessment, therefore, is to review progress made thus far towards the original objectives of ASEP - i.e., the development of a cost-effective HIV surveillance system and the building of capacities within national and local governments and private sector/non-governmental organizations to plan, conduct and monitor HIV prevention programs through education and outreach.

The overall recommendation of the Assessment Team is to extend ASEP's assistance for three additional years with a new completion date of September 30, 2000 and to provide additional funding to finance surveillance and education activities. This report presents specific recommendations for the three year extension intended to improve the effectiveness of surveillance and education activities, and to give greater support to identifying how surveillance and education activities can be sustained after USAID's assistance ends.

1.2 Summary Description of ASEP Activities: Surveillance and Education

ASEP provides funding for two main elements of the NASPCP - Surveillance and Education. ASEP's **Surveillance Component** consists of: a) the HIV Sentinel Surveillance System (HSS) currently conducted in 10 cities which provides periodic estimates of HIV prevalence rates among high-risk "groups", and (b) the HIV Behavioral Surveillance System (BSS) which monitors high-risk practices among target "groups". Six "groups" are included in the surveillance system; these are: registered female commercial sex workers (CSW), freelance CSWs, male CSWs, men who have sex with men (MSM), males being treated for sexually transmitted diseases, and injecting drug users (IDU). The first round of the HSS was conducted in June-August 1993 in two locations. Additional cities have been included in subsequent rounds conducted approximately every six months. Ten cities were covered in the seventh round completed in September-October 1996: Quezon, Pasay, Angeles, Baguio, Iloilo, Cebu, Cagayan de Oro, Davao, General Santos, and Zamboanga.

ASEP funds the direct costs of the HSS - i.e., materials and staff needed for the collection and testing of blood samples - through a grant to the WHO Western Pacific Regional Office in

Manila which established a sub-grant agreement with the New Tropical Medicine Foundation for the administration and financing of surveillance operations. WHO provided an HIV/AIDS advisor for the Philippines under the WHO/GPA which ended in 1996. WHO also provided technical support for the initial planning implementation of the HSS. WHO currently provides limited technical oversight of surveillance activities but plans to expand this to a full-time function. The WHO grant also funds two contract staff positions in the STD/HIV Unit of the DOH.

ASEP has committed \$2.1 million to date for the Surveillance Component. At current expenditure levels, this is sufficient to support activities through Fiscal Year (FY) 1998. Recommendations to reduce the scope of surveillance activities made by the Assessment Report will result in substantial cost reductions, perhaps as much as 50 percent, so that current funding should extend into FY 1999.

The Field Epidemiology Training Program (FETP) of the DOH is the principal counterpart for the surveillance component and is responsible for overall management, technical guidance and field supervision of the surveillance system. FETP works with field site managers and staff during the HSS rounds, providing technical oversight. FETP analyzes HSS data and disseminates the results.

At the site level, the HSS engages the City Health Office and Social Hygiene Clinics which provide the personnel needed to collect blood samples from the target "groups". Local NGOs who work with these target groups facilitate access to harder to reach individuals, e.g., IDUs. Testing is conducted by qualified local hospital laboratories. The Research Institute of Tropical Medicine (RITM) in Manila serves as the reference laboratory for the system. Each round of the HSS attempts to collect and test 300 blood samples from each of the six target "groups" so that reasonably reliable estimates can be obtained. In addition to HIV testing, the samples are tested for syphilis. The HSS also collects a very limited amount of behavioral information from those sampled.

The HSS is now operational in 10 cities contrary to the 1995 Mid-term Evaluation which recommended not expanding beyond 6 cities until infections rates of 2-3 percent were found among high-risk "groups". Not surprisingly, the HSS is encountering some problems. Only for registered female CSWs has the target of 300 individuals been obtained consistently at most HSS sites. The surveillance protocol is also supposed to be anonymous - unlinked; however, in actual practice, site managers report that providing test results serves as an inducement to people to participate in the testing.

Nonetheless, the HSS data indicate that infection rates even among high risk "groups" in general remains at low levels (i.e., less than 1%). The data also show that in particular cities, i.e., Angeles, HIV infection rates among freelance female CSWs now exceeds 1% and that syphilis rates among this group in Cebu is approximately 15%. In short, the HSS is providing the basis for monitoring trends among high risk "groups" nationally and in the specific cities/sites.

The Behavioral Surveillance System (BSS) was not initially part of ASEP's surveillance component. The 1995 Mid-term Evaluation strongly recommended accelerating the development of the BSS. After an unexplainably prolonged period of development (two years),

the BSS, consisting of eight questions, has been implemented in two cities - Legaspi and Batangas. However, the Mid-term Evaluation recommended the BSS be designed to complement and validate the limited behavioral data collected by the HSS which the present version of the BSS survey instrument fails to do.

ASEP's **Education Component** engages government agencies at the national and local levels with non-governmental organizations (NGOs) in a collaborative effort to provide information, promote lower-risk behavioral practices, and offer outreach services to individuals engaging in high risk behaviors. The Education component is directed toward institutionalizing public and private sector mechanisms that encourage behaviors which reduce the risk of contracting and transmitting HIV and other STDs, and that modify existing social norms which increase individual and collective vulnerability to HIV/STDs. Though HIV/AIDS infection rates among high-risk "groups" currently remain low, responding effectively to the HIV/AIDS problem in the Philippines is necessary to help prevent a future rapid increase of HIV infection. The Education component contributes directly to this end.

The Education component is implemented through a Cooperative Agreement with the Program for Appropriate Technology in Health (PATH). USAID has committed \$6.9 million for HIV/STD education activities through the PATH agreement. Current funding is sufficient to support program activities through FY 1998, but additional funds are needed to cover PATH's operational expenses (which is currently planned). Initially, PATH was directed to work through local partner NGOs in the three major regions of the country. These partner organizations, in turn, were to work directly with local NGO's to carry out education programs. The intention was to develop local institutional to support such activities in the future. However, for various reasons, this has not proven to be an ineffective or necessary arrangement. PATH has developed the staff capability and experience to work directly with local NGOs. Institutional capacity building is still supported with particular emphasis at the local government - local NGO level.

PATH has been highly effective in identifying and supporting NGO's in developing and implementing various education programs targeted on high-risk "groups" in their local communities. The NGO programs target the same high risk "groups" selected for surveillance; however, some also service additional risk "groups", i.e., the male clients of CSWs. It should be emphasized that the large majority of these programs focus on the very low income/poverty spectrum of the HIV/STD problem.

Each NGO program is tailored to the targeted client "group", this includes such services as information about HIV/STD infection and behavioral options for risk-reduction; out-reach activities by Community Health Outreach Workers and Peer Educators; drop-in centers and one-on-one counseling, referrals for STD treatment, distribution of condoms and syringes. In some cases, the NGO facilitates client group formation and mobilization which contribute to the objectives of ASEP and the education component.

To date, PATH has established 25 sub-grants under this component, with approximately 20 organizations currently conducting on-going programs. PATH has gradually expanded the scope of its activities into seven cities (which are also sentinel surveillance sites); these are Quezon, Pasay, Angeles, Iloilo, Cebu, Davao, and General Santos. Further expansion is planned; the extension of ASEP will provide the funding to do so.

An important element that PATH has included in all sub-grant agreements is baseline data collection and subsequent monitoring of program performance and effectiveness. Such data are used to help guide initial planning and mid-course modifications of NGO activities. Assessment of individual NGO program effectiveness is still in process; however, substantial progress has been made toward developing NGO capabilities, communication among NGOs and coordination between the NGOs and local government. These "process accomplishments" are important steps toward developing the institutional network needed to deliver these services, and coordination of activities with local government is critical for program effectiveness, as well as for the future sustainability of these activities.

By the end of 1996, the NGO education programs had reached approximately 70,000 individuals. To accomplish this, several hundred outreach workers and peer educators had to be trained. Some 3,663 referrals for HIV and STD testing have been made and approximately 1 million condoms have been distributed to primary risk groups.

In addition to these core NGO activities, the PATH Cooperative Agreement was amended to support several additional activities which contribute to preventing HIV/STD infection. Through the PATH agreement, a strategic plan for a National Safe Voluntary Blood Bank System was prepared. A further amendment added funding for an AIDS information exchange program for Filipino NGO, local government and national government officials and Thai counterparts who work on Thailand's national AIDS program. 35 individuals were able to visit Thailand under the Phil-Thai program. This contributed to fostering understanding and cooperation among those involved, resulting in greater coordination between NGOs and government agencies. The PATH agreement was also used to finance the development and implementation of an STD intervention to test approaches to Syndromic management.

In addition to the education activities supported through the PATH Cooperative Agreement, ASEP provided \$750,000 for mass communication activities conducted by Johns Hopkins University. These activities were intended to increase awareness about HIV/AIDS infection and prevention; however, the effectiveness of this activity is indeterminate.

1.3 ASEP's Implementation Environment

Over 800 HIV infections have been reported to the National HIV/AIDS Registry, though recent estimates based on epidemiological analysis of all the available HIV/AIDS data estimate the actual number of HIV infections at around 18,000 in the Philippines. In comparison to other countries where a significantly greater percentage of the population has been infected and where the rate of infection quickly accelerated, the Philippines can be considered as "pre-epidemic". The rate of new infections remains well below 1% for the general population as well as for most high-risk "groups" - the long anticipated "explosion" does not appear to have occurred yet. This situation could continue for the foreseeable future. On the one hand, this is good news for the country, but on the other hand, the prevalence of high risk behaviors is a serious concern. Condom usage is very low among high risk "groups" in large part because of customer refusal to use them. The commercial sex industry in the Philippines appears to be growing and engaging an increasing number of younger females in commercial sex work. Injecting drug use is a serious problem in several major cities and sharing of used needles is common. STD infection rates have reached critical levels in Angeles and Cebu among CSWs. However, there appears to be no concerted effort to respond to an increasingly serious STD

problem in the country. Funding for an STD control program is lacking and drugs are typically not available at public treatment centers. While other cultural factors work against a rapid increase of HIV infection (e.g., no tradition of a majority of men regularly visiting CSWs as in Thailand), the prevalence of high-risk behaviors might result in increasing HIV infection rates initially among the high at-risk "groups".

This situation poses both an opportunity and a challenge for ASEP, particularly its education activities. Information and behavioral change among high-risk groups is necessary to help prevent or at least slow any future increase in infection rates. However, with low infection rates, meaning few people actually know of individuals who are infected, motivating behavioral change is difficult. Similarly, low infection rates can have a perverse effect on budgetary allocations for HIV prevention and control. Policy makers may be reluctant to increase budgets for these activities since the problem may not seem critical to them at this time.

Future budget allocations for surveillance and education activities will, of course, be critical for their sustainability. Donor funding cannot be counted on indefinitely. ASEP has been implemented during a period of profound economic improvement in the Philippines. Beginning in 1993, the Ramos Administration has made a number of major policy changes in key sectors, e.g., banking and telecommunications, that have encouraged increased foreign investment, expanded export earning and greater employment opportunities. Current estimates indicate GNP growth for 1997 is likely to reach 7 percent. It seems that the Philippines has entered a period of "economic take-off" similar to neighboring Southeast Asian countries.

Despite such improving economic conditions, national and local government budgets remain under severe pressure. At the national level, the Government faces critical budget limitations in the face of major financial requirements to keep the country moving forward. Modernizing infrastructure throughout the country, expanding the quality of education for a young and expanding population, and delivery of various social services are priorities. Current government expenditures for health are widely recognized as insufficient with no major improvement expected in the next few years. Within that health budget, allocations for the STD/HIV Unit's activities have fallen from P42 million in 1996 to a proposed P39 million for 1997 as cutbacks in resources become necessary. As the number of AIDS cases increases, these people will turn to government facilities for care, the costs of which could consume a major portion of funds available for HIV-related activities.

A major change in the "environment" affecting ASEP has been the devolution of health services from the national to local government levels. The Local Government Code of 1991 mandated that health service delivery would become the responsibility of local governments. Budget allocations would be increased to the local governments and taxing authorities expanded so as to help local governments pay for these services. This resulted in a profound change in the health sector, particularly with respect to DOH operations and their new relationship with local governments. This process has been underway since 1993 and it is fair to say that it is still evolving. For ASEP, this meant giving much greater emphasis to the local government level, far beyond what was expected at the time ASEP was designed. Similar to the national government, local government budgets are strained to provide the expanded range of services in a number of sectors which resulted from devolution. Local governments now determine their priorities for health and other services, as well as priorities within their health budgets.

This too poses serious questions about the financial sustainability of ASEP activities when USAID assistance ends. To what extent will local governments be willing and able to fund and staff these activities at adequate levels in the face of numerous other competing demands for limited budget resources. While many other donors are funding STD/HIV-related activities, which includes WHO, JICA, the Japanese Embassy, UNICEF, AusAID, KfW and the EC, and donor coordination has been very good, USAID remains by far the largest contributor. Moreover, the days of looking to donor funding for program support are coming to an end, especially as the country's economy improves and the Philippines is, at some point, "graduated" from donor aid.

SECTION 2: HIV SENTINEL SURVEILLANCE AND BEHAVAIORAL SURVEILLANCE SYSTEMS

2.1 Findings

The major findings of the 1995 Mid-term Evaluation remain almost the same two years later. They include:

- Generally low HIV prevalence (<1%) in almost all of the targeted HIV Sentinel Surveillance (HSS) high-risk "groups".
- With the exception of registered FCSWs, smaller and generally inadequate numbers have been collected for all of the other targeted HSS high-risk "groups".
- Relatively high syphilis rates (up to 16%) found in many of the targeted HSS high-risk "groups".
- Generally low condom usage rates, especially among freelance FCSWs and males with multiple sex partners.
- Lack of a uniform behavioral surveillance questionnaire used by DOH for HSS and NGOs for their behavioral monitoring surveys.

The Mid-term Evaluation made a number of recommendations about the further development of surveillance activities which have only been partially followed over the past two years (see Annex 4 for the 1995 recommendations). Since the Mid-term Evaluation, no modifications of the HSS protocol with regards to the target groups, sample size requested, and periodicity of HSS rounds (i.e., biannual) have been made. The number of HSS sites have been increased incrementally to eight in the fifth round (September/October, 1995), to ten in the sixth round (March/April, 1996). A new protocol for behavioral surveillance was developed and pre-tested in 1995 and in the seventh and latest HSS round (September/October, 1996) this behavioral sentinel surveillance (BSS) protocol was carried out in two new sites (Batangas City and Legazpi City). In these two sites only the new BSS protocol was carried out and the standard HSS protocol that includes collection of blood samples for HIV and syphilis testing was omitted. Several separate behavioral surveys of high risk "groups" were carried out by NGOs using a questionnaire that had questions about condom use that were not comparable to those used for the HSS or BSS rounds.

HSS findings for 1995 and 1996 indicate that HIV prevalence in the Philippines is still very low in almost all of the target high-risk "groups". However, in one HSS target "group" (registered FCSWs), in one HSS site (Angeles City), an HIV positive rate close to 1% was detected in four consecutive HSS rounds beginning in March/April, 1995. In the latest HSS round in September/October, 1996, the HIV prevalence rate in this group was found to be over 1% (4 positives out of 300 tested - 1.3%). Overall, among all registered FCSWs tested in all of the ten HSS sites during the latest HSS round, a total of six positives were found in over 3,000 tested for an overall prevalence rate of about 1 per 500 or about 0.2%. In the prior HSS round (March/April, 1996) the overall prevalence rate in this "group" at all of the HSS sites was about 1 per 1500 or about 0.07%. In other HSS risk "groups", only a single HIV infection was detected in a male STD patient in Quezon City in the March/April, 1996 HSS round and a single injecting drug user was found to be HIV-positive in Cebu City in the most recent (September/October, 1996). These are very low HIV prevalence rates! HIV prevalence rates in similar risk "groups" in Thailand and Cambodia are about 50 percent!

Since 1995, the requested sample size of about 300 continues to be attained for registered FCSWs at almost all of the HSS sites. However, the sample sizes of most of the other high risk "groups", especially high risk male "groups" continue to be well less than the requested 300 - sometimes well less than 100.

The last few HSS rounds have also continued to show relatively high seropositive rates for syphilis (up to 16%), especially in the freelance FCSWs and among males with multiple sex partners. In contrast, syphilis rates are relatively low among all of the registered FCSWs.

HSS data on injecting drug use indicate that the potential for rapid spread of HIV in this risk group is very large because the reported practice of sharing injection equipment is generally very high - 77% in Cebu and 100% in General Santos City.

The HSS findings regarding condom use continue to show relatively low usage rates among men with multiple sex partners and freelance FCSWs. The reported rate of consistent condom use by registered FCSWs are, in general, much higher compared to all of the other target "groups" and appear to be generally higher in those areas with an ASEP educational/outreach component. The results of the first BSS round in the two new sites have not been finalized for distribution.

Interviewers from the University of Southern Philippines Foundation (USPF) conducted two rounds (April/May, 1996 and October, 1996) of behavioral monitoring surveys in several high risk "groups" in Cebu. A major objective of these surveys was to assess changes in condom usage to correlate with potential contact to the education/outreach activities of NGOs working in Cebu. **Preliminary drafts of these surveys have been distributed and the general findings appear to support the conclusion that the ASEP education/outreach program messages to use condoms during high-risk sexual encounters are having a positive impact on the respondents.** Self-reported use of condoms in such high risk sexual encounters are increasing.

These findings of the HSS rounds have been widely disseminated by the FETP via a detailed report to all of the participating staff for the HSS rounds as well as to the public, external donors, NGOs, and policy makers. The format of this report has been constantly evolving and the most recent report provides a couple of pages of simple descriptive text describing the current HIV/AIDS findings in the Philippines along with detailed tables containing all of the collected data. In addition, DOH has convened biannual meetings with HSS staff (FETP and LGUs), and participating NGOs to review management and technical issues related to each of the HSS rounds.

Because the HIV findings are so low, the FETP has started to focus more on distributing the data regarding the relatively high syphilis antibody rates that have been detected (up to 16% among freelance female commercial sex workers in Cebu City), and the relatively low condom usage rates found in most of the risk groups, especially among males who have multiple male and/or female sexual partners. These latter findings have been used to emphasize the great potential for a rapid increase of HIV infections in these risk "groups" if the high level of these risk behaviors are not rapidly reduced.

2.2 Conclusions and Recommendations - HIV Sentinel Surveillance Guidelines

The initial field guidelines for HSS were developed by the Surveillance, Forecasting, and Impact Assessment (SFI) unit of the GPA/WHO during the late 1980s and HSS systems have been systematically implemented in only a few countries in Asia. It needs to be emphasized that any

national HSS system should adapt or tailor the SFI/GPA/WHO field guidelines or protocol to fit regional and local estimates of the general distribution and prevalence of HIV infections.

One rigid HSS protocol cannot be appropriate for all epidemiologic situations. What may have been appropriate during the first few rounds of HSS in the Philippines may now, after seven HSS rounds, not be appropriate for all HSS sites or risk groups. The following questions about the major variables of an HSS system need to be carefully weighted based on epidemiologic factors as well as staffing and resource considerations in order to make appropriate and cost effective decisions regarding possible changes to the existing national HSS protocol in the Philippines that will not seriously compromise the primary objective of sentinel surveillance for HIV.

- How many geographical sites are needed?
- How many risk "groups" should be included?
- How often do HSS rounds need to be repeated?
- What are adequate sample sizes?
- Can an HSS round be extended beyond two months?
- Do all HSS sites have to start at the same time?
- Can saliva tests be used for HSS?

The following "answers" to these questions serve as a basis for providing specific recommendations for changes and refinements to the HSS protocol in the Philippines.

How many HSS sites are needed?

A frequent criticism of starting and restricting sentinel HIV surveillance in only a few of the highest risk areas (usually the largest cities) is that possible HIV epidemics in other areas and populations will go undetected. While this is always a possibility, more than a decade of experience in public health surveillance of HIV/AIDS indicate that concern about HIV epidemics occurring outside of urban areas before high HIV seroprevalence levels are reached in the large cities are unfounded. **Since the HIV prevalence rates detected by HSS in 1996 are still very low in the largest cities in the Philippines, there is no need to expand the number of geographic HSS sites.** It was recommended as a result of the Mid-term Evaluation that if HIV levels in some areas increased to about 2-3% in some high-risk "groups", then expansion of the number of geographic sites could be considered. However, in the absence of any significant increased HIV rate in the targeted risk "groups", the number of HSS sites have been increased incrementally to eight in the fifth round (September/October, 1995), to ten in the sixth round (March/April, 1996).

RECOMMENDATION: At the present time, a total of 6 to 8 cities would be adequate to monitor HIV prevalence trends in the Philippines.

How many risk groups should be included in HSS?

The populations (risk groups) selected for HSS should allow for the monitoring of all the major HIV risk behaviors or factors known to be prevalent in any given area. In the largest cities in the Philippines this would likely require at least three "groups" - men who have multiple male sex partners (MSM), FCSWs, and injecting drug users (IDUs). In many of the smaller cities the number of MSMs and IDUs may be too small to permit any effective monitoring of the HIV prevalence in these risk populations using HSS sampling methods. To monitor HIV prevalence trends among heterosexuals with multiple sex partners, only one risk group would usually be needed. Experience in many countries, where HIV epidemics have reached 5-10% among

several heterosexual high HIV risk groups such as FCSWs and/or heterosexual STD patients, also indicate that spread to the "general" population of heterosexuals as reflected by HIV seroprevalence levels among ante-natal women may take up to 5 years or more to reach about 1%. Thus, until HIV prevalence rates in the highest heterosexual risk groups reach about 5% there is no need to include easy to reach groups such as ante-natal women. Up to 1997, the DOH has routinely requested the following six risk groups to be included in all sites - Registered female sex workers (FCSW), freelance female sex workers (FLSW), male sex workers (MCSW), male STD patients (MSTD), men having sex with men (MSM), and injecting drug users (IDU). Of these six groups, three groups (FCSW, FLSW, and MSTD) are used to monitor HIV prevalence in the heterosexual population. Not all three groups are needed.

RECOMMENDATION: At the present time, a minimum of three risk groups (MSM, FCSWs, and IDUs) are needed in the largest cities (Manila and Cebu). In all of the other cities, only FCSWs should be routinely selected for HSS. If epidemiologic studies indicate that the number of MSM and/or IDUs are relatively large (i.e., estimated to be at least a few thousand) then these risk groups should be included in HSS at these sites.

How often should HSS rounds be conducted?

The basic objective of HSS is to provide early warning of a rapidly expanding HIV epidemic. To date in the Philippines, the HSS rounds have not documented a very rapidly increasing HIV epidemic. Based on this experience, it would appear that HSS rounds in most of the geographic sites and risk groups can be carried out annually instead of biannually. However, in the most recent HSS round, HIV prevalence of registered FCSWs in Angeles City reached about 1% and an HIV infected IDU was detected in Cebu where the collected behavioral data indicate that the majority of IDUs share injection equipment. Thus, the potential for a rapid rise in HIV prevalence in these cities and in these risk groups is very large and biannual HSS rounds may still be indicated in these sites.

RECOMMENDATION: HSS rounds can be carried out annually in all of the sites except for Angeles City and Cebu, where biannual rounds should be maintained.

What are adequate sample sizes for HSS?

The sample size initially recommended by SFI/GPA/WHO was based more on practicality than on any rigorous statistical basis. If HIV prevalence is estimated from the available surveillance data to be low (i.e., well less than 1 percent), is there a need to attempt to determine precisely how low the actual prevalence might be? It may be quite sufficient for HIV/AIDS prevention and control programs to be aware of the following general levels of HIV prevalence for different population "groups":

- A. HIV not detected
- B. HIV present and prevalence probably very low (less than 0.5 percent?)
- C. HIV prevalence close to 1 percent
- D. HIV prevalence more than 5 percent

These arbitrary HIV prevalence levels are within the capability of most public health HIV/AIDS surveillance systems to measure and monitor with reasonable sample sizes (i.e., about 2 to 3 hundred). To be able to measure any specific prevalence level below 1 percent with any degree of statistical confidence would require very large sample sizes, and the additional problems of biases in sample selection and participation also contributes to the general lack of precision in public health surveillance data.

In Thailand, HSS sample sizes have averaged about from 1 to 2 hundred for each sentinel group. This sample size was too low at the beginning of the HIV epidemic, but when HIV prevalence reached levels of more than 30% in many groups, this sample size has been more than adequate.

RECOMMENDATION: HSS sample size for the Philippines should remain at about 200-300. If a minimum of 200 cannot be collected in the current allotted time period, then the collection period can be extended (see below). If only less than 100 can be collected, then this group should be omitted from the HSS rounds and alternative survey collection methods using NGO groups be attempted if it is believed that there may be at least several thousand or more persons engaged in this risk behavior in this HSS site.

Can the implementation period of a HSS round be extended beyond two months?

The purpose of trying to keep the collection period to as short a time interval as possible is to be able to measure a precise period prevalence. A two month period was chosen to also avoid too many repeat collections for the same person. However, lengthening the HSS collection period to 3-4 months (if needed) would not seriously compromise the measurement of HIV prevalence in the Philippines HSS because at present the spread of HIV in the HSS groups appears to be slow.

RECOMMENDATION: The HSS sample collection period can be extended to 3-4 months if needed.

Do all HSS sites have to start an HSS round at the same time?

HSS was designed to monitor HIV prevalence and trends in target risk groups. This objective would not be compromised if different sites carried out their HSS rounds at different times.

RECOMMENDATION: All HSS sites do not have to be carried out during the same calendar time.

Can saliva tests be used for HSS?

The new saliva and oral transudate tests for HIV antibody are considered as sensitive and specific as the accepted blood tests. Since HSS should be carried out without personal identifying information, there is no reason why the "saliva" tests cannot be used for HSS. The main obstacle may be that the cost of these new tests are probably more expensive than current blood tests.

RECOMMENDATION: Use of the "saliva" test for HSS should be explored for those groups who are reluctant to have their blood drawn.

Behavioral Surveillance Issues:

Clear and/or formal guidelines have not been developed for behavioral surveillance by any international agency. Several key recommendations of the mid-term evaluation were directed at improving the coordination and validation of the limited behavioral data that were being collected during the HSS rounds. One recommendation was that collection of behavioral data should be coordinated with the HSS rounds, but probably should be carried out at a different

time and with different staff. For example, HSS can be scheduled at a site from January to February and from July to August and the behavioral surveillance survey (BSS) from April to May and October to November. Behavioral data from the BSS round can then be used to evaluate and validate the more limited behavioral data collected in the HSS round. This recommendation was not followed. Instead, the behavioral sentinel surveillance (BSS) protocol that was developed and field tested in Pasay City in 1995 was implemented in two new sites (Batangas City and Legazpi City) during the seventh (last) HSS round in October, 1996. However, in these two sites only the new BSS protocol was carried out and the standard HSS protocol that includes collection of blood samples for HIV and syphilis testing was omitted. Thus, one of the primary objectives of BSS, which was to complement and perhaps help to validate the behavioral data collected in the HSS rounds, could not be accomplished.

Another major recommendation regarding the collection of behavioral data that was made by the mid-term evaluation was that DOH, PATH, and major NGOs should collectively decide what behavioral data are needed to evaluate the overall effectiveness of ASEP educational activities. The FETP was requested to support the development of standard questions for the routine collection of behavioral data. However, since 1995, several separate behavioral surveys of high risk "groups" were carried out by NGOs using a questionnaire that had questions about condom use that were not comparable to those used for the HSS or BSS rounds. Thus, it will be difficult if not impossible to compare the condom usage data from these surveys with those collected in the HSS rounds because the questions on condom use are not the same. The NGO question is: "was a condom used during the last commercial sex partner encounter"; whereas the BSS question is: "were condoms always, sometimes, or never used during the last week or month for all sexual partners".

RECOMMENDATION: At a minimum, the DOH has to add a question to their HSS and BSS questionnaires that will obtain the same data on condom usage that are collected by the NGOs.

RECOMMENDATION: In addition, both the NGO and DOH questionnaires should collect information on condom usage for the last commercial sex partner as well as condom usage with the last sexual encounter with a spouse, boy friend, or "steady/regular" partner.

RECOMMENDATION FOR IMPLEMENTATION OF HSS MODIFICATIONS: The DOH should consider all of the recommendations made in this report regarding modification of the HSS protocol and implementation of the BSS protocol. For those recommendations which they agree with, a specific action plan and schedule for implementation should be completed within three months after receipt of this report. For those recommendations that DOH either does not agree with or believes that it cannot implement, a written report should be submitted within three months to describe the disagreement with or obstacles for implementing the specific recommendation(s) in question.

SECTION 3: INFORMATION, EDUCATION AND COMMUNICATION

3.1 Targeting:

Findings

HIV sentinel surveillance continues to indicate that HIV has not yet spread to the general population of the Philippines. As noted in the mid-term evaluation, free-lance sex workers are at higher risk of HIV infection than registered sex workers. Likewise, there also continues to be an overlap between the IDU and CSW populations. However, it is clear that HIV is present in the Philippines, and the patterns of sexual and drug use behavior identified through the Behavioral Sentinel Surveillance, project evaluations, in-country research projects, and from the team's observations indicate that the potential for rapid spread of HIV within these targeted populations is significant. The current HIV intervention projects are significantly helping the Philippines to avoid what could potentially be a serious epidemic. Should HIV incidence and prevalence increase in the near future, the current targeted interventions, and the institutional capacity to provide prevention activities that has been built through ASEP, will be a great asset to suppression of a wide scale epidemic as seen in other South Asian countries.

Targeting of intervention activities has been focused on specified risk groups including commercial sex workers (registered and freelance), men who have sex with men, injecting drug users, men who have sex with CSWs, and persons who have had sexually transmitted diseases. These groups do appear to be at high risk of HIV infection in many areas of the country. Peer education methods have been used to reach these target groups with good success, but it has sometimes been difficult to identify, enlist, and retain peer educators for some locations and population groups.

During site visits to freelance sex locations, girls as young as 11 to 12 years old were observed as members of freelance sex worker groups. This has been corroborated through discussions with the implementing NGOs who have noted that the presence of very young female sex workers is a common and growing problem. The strategy for HIV prevention has been primarily designed for persons who are physically, emotionally, and intellectually more mature than these pre-adolescents, and thus may not be appropriate for these young girls. Moreover, such young girls may face special obstacles to risk reduction due to their age and developmental stage.

Implementing NGOs are targeted geographically, such that each NGO has an identified geographic territory carefully mapped out in each city. This has resulted in a system in which practically all NGOs providing HIV prevention services address multiple target groups in each geographic area. This strong geographic focus has resulted in some conflicts between NGOs over geographic territory, and it has also resulted in weak identification with individual target groups by the NGOs in many instances. Moreover, since the prevailing intervention modality is peer education, the lack of an association between NGOs and specific target groups has resulted in "peer" education sometimes being provided by non-peer individuals.

This geographically based targeting system was adopted due to the pre-existing formation of NGOs in the Philippines along geographic boundaries. Many of the NGOs supported through ASEP were previously incorporated to organize urban poor communities, thus the geographic emphasis made sense for those programs. Many of the ASEP supported NGOs continue to

provides a myriad of services, from legal services to family planning. The wide range of services provided and target groups accessed by the implementing NGOs results in complex management structures and some difficulty in evaluating the projects due to the mix of clients served. However, there are also many positive aspects to the geographic targeting, as it has fostered sustainability of NGOs through diversity of funding opportunities, and has enhanced access to hard to reach target populations.

Conclusions

Female commercial sex workers, men who have sex with men, injecting drug users, and other men at risk (primarily men who frequently visit CSWs or have had STDs) continue to be the "groups" most likely to experience rapid increase of HIV infection based on the available data on HIV and STD risk behavior of various "groups". Reaching these groups through peer education continues to be the most culturally appropriate and pragmatic approach given the unique social networks of the target groups.

Very young sex workers need to have a prevention strategy that is specially designed to meet their needs. This strategy needs to be incorporated into the interventions of all NGOs targeting CSWs. The actual prevalence of child sex workers and the factors that are promoting such young girls to enter and stay in the sex industry are currently unknown, and estimates are based on anecdotal data.

The geographic organization of local NGOs has both positive and negative aspects, and would likely require a strong effort to reorganize NGO service provision by target group rather than by geographic territory.

Recommendations

- Targeting of CSWs, MSM, IDU, and other men at risk through peer education and counseling should be continued by NGOs working with PATH.
- The geographic division of services should not be changed at this time. Given the established geographic focus of the implementing NGOs, it would be too disruptive to try and reorient the NGOs by target groups at this time. There should, however, be an increased effort to foster collaboration and cooperation across NGOs, and the sense of territorialism that exists should be addressed in the regular meetings of the NGOs. PATH should take the lead in fostering collaboration and cooperation across NGOs.
- Additional target groups that should be added include: (1) child sex workers with each NGO working with CSWs using specialized intervention approaches for this population [this is also discussed later in the education section]; (2) gate keepers, such as sex establishment managers and owners, illicit drug suppliers, and Social Hygiene Clinic personnel; and (3) policy makers, such as City Health Officers AND LGU political leaders. The last two target groups are discussed later in section 3.6 on policy.

3.2 IEC Theory and Strategy:

Findings

Risk perception has been difficult to sustain with few HIV infections, and fewer still AIDS cases and deaths from AIDS, evident to the target populations. Thus, risk reduction via behavior change has been difficult to achieve. Perhaps the biggest challenge to the ASEP program is how to promote behavior change among populations at risk.

Field level implementation of intervention activities has been conducted with a variety of NGOs throughout the country. The implementing NGOs primarily utilize a theoretical approach based on health education using peer educators to reach the specified target groups. The strong emphasis on AIDS education has resulted in perhaps less emphasis on psychological, social, and environmental factors which promote risk behavior.

Personalized counseling is not strongly emphasized among the Community Health Outreach Workers (CHOWs) and peer educators working with the NGOs, although it is a stated goal of the PATH educational component. The CHOWs and peer educators do seem well trained to provide educational information, however, they are not well trained in counseling approaches which are much more interpersonal than provision of educational information, and which require a more intensive level of ongoing monitoring and training to sustain. PATH does not currently have enough staff to mount the level of training and monitoring of peer education activities to assure that personalized counseling is regularly conducted.

Psychological and social correlates of risk behavior such as personalized risk assessment, outcome expectations from behavior change, perceptions of self-efficacy to make behavioral changes, interpersonal and negotiation skill building, and perceptions of social norms are not systematically addressed by CHOWs and peer educators when they interact with the targeted populations. There is a need for additional strategic planning and staff training to incorporate these issues into the strategic educational plan.

It is currently unclear where the target populations are in terms of their stage of change (pre-contemplative, contemplative, ready for change, short term change occurred, or long term maintenance of change occurring). As a result, the NGOs may be providing behavior change interventions that are inappropriate to the current stage of change of the individuals accessed by the projects. (See Annex 3 for a summary of the stages of change and their associated intervention approaches.)

Some of the NGOs have been working with IDUs to reduce HIV transmission through drug injecting. This is partially accomplished through teaching IDUs to clean their syringes before sharing, provision of bleach kits for cleaning syringes, and, of course, teaching the IDUs to not share drug equipment. Needle and syringe exchange (this does not involve USAID funds) is also implemented in Cebu by one NGO. It is not clear that the injecting drug users are less likely to share the syringes due to the provision of new syringes through needle exchange. The efficacy of needle exchange in reducing HIV incidence is currently being hotly debated in the scientific literature. Providing clean needles and bleach kits to the drug users does clearly give the peer educators and CHOWs improved access to the target group of IDUs.

The BSS and HSS data are not currently used regularly in the planning of educational activities and strategies. There have been attempts by PATH to coordinate more closely with the FETP on issues related to the sentinel surveillance, however they have not been successful in forging an ongoing close collaboration with FETP regarding surveillance. It is important to note that, to date, HIV rates have been so low as to provide little assistance in planning at this stage of the epidemic. However, the syphilis serology results from the HIV Sentinel Surveillance and behavioral data from the Behavioral Sentinel Surveillance have identified significant levels of syphilis infection and risk behavior in some regions and target groups, but little coordinated action has been taken to address specific problems. In theory, it would be best if PATH's evaluation indicators collected from their target populations informed the DOH prevention strategies, and if the Sentinel surveillance information guided PATH's prevention activities.

There are many environmental factors promoting risk behavior and HIV/STD infection among the target groups. These include some sex establishment managers and “mama sans” who discourage condom use among the sex workers, poor quality STD services, lack of protection from abusive clients by sex establishment management and police, and a lack of monitoring and regulation of sex establishments when STD incidence is identified as high from Social Hygiene Clinic data. Currently, PATH does little to affect changes at the policy level, such as encouraging government support of STD diagnosis and treatment, as this is not currently included in their scope of work.

Conclusions

The emphasis on peer education is a strong aspect of the IEC strategy; however, there is a need to enhance the regular use of interpersonal counseling, training, and monitoring with implementing NGOs. Additional training is needed to assure that the peer educators actively engage in interpersonal counseling with the target audiences. Additional staff will be needed at PATH to provide such technical training and oversight. Moreover, there is a need for greater attention to psychological, social, policy, and environmental factors that are correlated with risk behavior.

It would be useful to assess whether needle exchanges with IDUs are reducing HIV transmission through sharing, especially in the absence of intensive interpersonal counseling, and the lack of drug addiction treatment. This could be examined through rapid ethnographic research techniques. (Annex 5 cites additional research topics that might be useful for guiding future IEC activities.)

Recommendations

- The strong emphasis on peer education should be continued.
- Training should be provided on interpersonal counseling to address: (1) personalized risk assessment; (2) condom negotiation and safer injecting drug use skills and self-efficacy; (3) outcome expectations; and (4) behavioral impacts on social networks and family, and other such correlates of risk behavior. Ongoing monitoring and training activities should be added to PATH's strategy to assure that personalized counseling is occurring.

- PATH and its NGOs should address structural and environmental factors associated with risk behavior, such as collective commitment of CSWs, “mama sans”, owners and managers to support condom use, organization of sex workers, and policy changes to create a supportive environment for risk reduction such as a 100% condom use monitoring policy by public health officials.
- Address policy issues that hinder HIV and STD prevention efforts (this is discussed in greater detail below).

3.3 IEC Media:

Findings

Knowledge of routes of infection for HIV is high among both the general public and the ASEP target groups persist. However, many false beliefs about infection and cure of HIV persist. There is also a significant fear of persons with AIDS among the general public. Persons with AIDS (although few at the current time) face significant stigma and social isolation.

There have been several mass media Public Service Announcements (PSAs) produced and aired on national television. These PSAs have addressed STD and HIV through use of creative and symbolic depiction of sensitive topics (e.g., a rusty pipe to represent chancre sores, a stained dress representing vaginal discharge, and bananas to represent penises). The PSAs were likewise well produced and professionally filmed and acted. These PSAs have been limited in duration to campaigns of several months each.

Small media materials, such as brochures and comics, are written at a high level of reading comprehension, and include both Tagalog and Cebuano languages (especially Tagalog) (spoken by over 90% of the population of the Philippines, and almost all of the target group members). Many of the NGOs supported by ASEP expressed a need for a greater quantity of IEC materials. Most of the IEC materials that are available focus on provision of biologic information about HIV transmission, AIDS, and ways to protect yourself from infection. As with the peer education, the IEC materials do not routinely address social, psychological, and environmental precursors of HIV risk behavior. Pre-testing of IEC materials with target groups is not routinely conducted.

Some of the available IEC materials do not contain illustrations, and illustrations that are present tend to be simple drawings. IEC materials do not often depict characters who are similar in characteristics to the target population -- for example, IEC materials for sex workers which illustrate sex workers, or IEC materials for gay men which have characters which are identified as gay men. There are some exceptions to this, such as a series of comic books developed by Reach Out targeting men who have sex with men. There is also a small flip chart that is available from PATH that contains some explicit illustrations, however, access to this is limited to NGO leaders associated with ASEP due to its graphic nature. This approach was taken to avoid offending conservative policy makers and the general public, and due to the previous negative reaction of religious leaders to graphic materials. The National Government now requires that all IEC materials be cleared by a Censor Board which does not allow for “pornographic” depictions of sexual behavior.

Many of the IEC materials used for STD and AIDS prevention depict oozing and bloody genital lesions, or depictions of persons with AIDS with scars and open wounds. Some of these posters were designed for clinical training purposes, not for behavior change interventions. Such depictions are found in STD clinics and in posters found in NGO offices, and are used by NGOs in street educational efforts. It is possible that such depictions of STDs will promote the belief that STDs are associated with genital lesions (thus neglecting the common occurrence of asymptomatic STDs), and that persons with HIV and AIDS are readily identifiable, infectious through casual contact, and to be avoided. Finally, such images tend to associate STD screening with negative outcomes, and thus may dissuade many from seeking treatment when symptoms first appear.

In some NGO locations, there is fear of having AIDS IEC materials and condoms available, as they can be used as evidence of illegal activities. The same is true of needles and syringes, which can be used as evidence of drug use. These fears possibly limit the capacity of the NGO programs to reach the target populations.

Conclusions

Given the current low number of HIV infections and AIDS cases in the Philippine, mass media should not be a major component of the overall project at this time. Small media should be enhanced to better meet the needs of the target audiences, and there should be more copies of small media produced, pre-tested, and distributed. Use of highly negative images in media should be discouraged. PATH should take the lead in development and distribution of IEC high quality IEC materials for HIV prevention (within the limits of USAID regulations), but should also make use of available high quality materials.

Recommendations

- Mass media should be limited to PSAs and should address the fear of persons with AIDS, social norms regarding sex work and child sex workers, and link STD symptoms to HIV risk.
- Small media (brochures, comics, photo-novella) should include: a) lower literacy materials; b) use of graphics and stories; c) materials for each target group; d) attention to social, psychological, and environmental factors beyond health information; and e) linking STD experiences to HIV risk.
- Pre-testing of newly produced IEC materials should be conducted prior to production and distribution. Currently used IEC materials that are frequently used which have not been pre-tested should be pre-tested with target populations when feasible.
- An adequate budget is needed for copies of IEC materials at the NGO level. PATH should be given a budget to copy and distribute available IEC materials as is needed by the sub-projects.
- PATH should conduct an assessment of available IEC materials to identify the type and quality of materials currently available by target group and language. This assessment should then be used to develop a plan for development of future IEC materials.

- PATH should develop a clearinghouse of quality IEC materials that is accessible to the NGOs.
- Public use of IEC posters and flyers depicting STD lesions, and persons with HIV infection and AIDS who have scars and lesions (some of which were originally developed for clinical training purposes) should be avoided and discouraged. For example, PATH should address this in Social Hygiene Clinics through policy activities.
- Mass media should be primarily limited to PSAs which address [in this order]: (1) social norms regarding sexual risk behavior and child sex work, (2) linking STD symptoms to HIV risk, (3) social acceptability of condoms, and (4) fear and stigma of persons with HIV and AIDS.

3.4 Evaluation:

Findings

Evaluation of NGO sub-projects is conducted bi-annually at each site. Evaluation has focused primarily on outcome indicators such as HIV risk behavior, rather than the factors that are associated with reduced risk behavior such as knowledge, self-efficacy, outcome expectations, perceived social norms, etc. There is also a strong self-selection sampling bias in the evaluation of most sub-projects due to the use of convenience sampling. Since the NGOs also administer the surveys themselves, it is possible that additional sampling and self-report biases are present. They may sample those persons who are easiest to reach, and the respondents are being asked questions about their risk behavior from the same people who have been counseling them to reduce risk behavior. The current core protocol for the administration of evaluation surveys does not include systematic guidelines for sampling. Evaluation questions are also different from Behavioral Sentinel Surveillance questions, making comparisons difficult across the two types of surveys in the same cities.

As noted earlier, it does not appear that IEC materials are always pre-tested among the risk groups targeted. There is also a desire by many of the NGOs to have more evaluation of intervention activities to assist them in identifying 'what works' in changing behavior at the sub-project level.

Sub-project monitoring is conducted primarily by PATH's Manila staff and consultants through site visits, interviews with staff, review of official documents, and observation. It has been difficult for PATH to monitor all of NGOs adequately due to staff and time limitations. In general, the monitoring has reported high quality work by the NGOs. PATH has managed to maintain a constructive relationship with the sub-recipients through the evaluation process, and the NGOs appear to value the evaluation efforts and feedback.

Conclusions

The biannual evaluation of the sub-projects is not needed for reasonable project monitoring. An annual implementation of the surveys would be more than adequate. The surveys utilized in the evaluations should include more intermediate measures of behavior change and psychological measures associated with behavior change. The methods utilized in evaluating the sub-projects need to be revised to avoid selection and response biases. The capacity of

PATH to monitor project management and implementation, train staff, and evaluate sub-project outcome indicators is limited due to staff and time constraints.

Recommendations

- The evaluation surveys should add outcome indicators on psychological and social correlates of risk, such as risk perception, health seeking behavior, intent to change behavior, etc. Assessment of the specific goals of each sub-project should be conducted, and measures specific to the project goals should be included. For example, projects that strive to increase risk perception should measure this construct in the evaluation of the sub-project. Baseline data collection will need to be established for these measures, the goals of the projects adjusted accordingly, and benchmark set for these measures for each population target group by site.
- PATH should develop a core protocol for evaluation activities that addresses the sampling and respondent biases noted earlier.
- Behavioral measures used as outcome measures should be harmonized with Behavioral Sentinel Surveillance data.
- The measurement intervals for evaluation of NGO projects should be changed from bi-annual to annual. It is likewise acceptable to stagger the evaluations of NGO sub-projects if this will lead to a more efficient collection of the evaluation data.
- PATH should expand its evaluation to also include occasional evaluation activities on specific approaches and IEC materials that are being used at different sites in the field to identify approaches that are working well to change risk behavior.
- PATH should continue to strive to use sentinel surveillance data better in planning of sub-project activities. This should be attempted through regular meetings with Sentinel Surveillance staff at DOH.
- PATH should investigate the use of an independent institution, such as a local university or market research firm, to conduct the field level evaluation activities. Such an external institution could work closely with the NGOs to administer the surveys. Interviews should never be conducted by persons who also provide prevention education and counseling.

3.5 Child Sex Workers:

Findings

Many of the freelance CSWs are very young and the IEC approach utilized by NGOs is probably not effective for pre-adolescents. Some of these young girls (up to a third in many of the sites we visited) appear to be only 11 to 12 years old. The number and actual age of these girls is uncertain, as they lie about their age to avoid police harassment. Risk reduction intervention with girls of this age requires special strategies given the lower level of intellectual, physical, and emotional maturity. Our interviews with these young girls indicated that they are often either sold into the sex industry, or forced from their homes due to poverty. It also appears that the older sex workers, mama sans, and pimps provide the primary emotional and

social support to these pre-adolescent sex workers. This lack of familial and social support outside of sex work likely makes it extremely difficult for them to leave sex work, or adequately protect themselves from physical abuse and sexually transmitted infections, such as HIV.

Conclusions

A special strategy is needed to effectively reach young CSWs. This strategy needs to be formulated based on descriptive research on the scope and distribution of the problem.

Recommendations

- USAID should support rapid descriptive and ethnographic research to: a) identify the extent and distribution of child sex workers, b) trace the factors promoting entry of children into sex work, c) identify the special needs of child sex workers regarding HIV/STD prevention, and (4) develop a strategy for addressing HIV and STD, and physical and emotional abuse among child sex workers. This research should also be used to develop a policy strategy to reduce the harm to, and suppress use of, children as sex workers.
- A special strategy for child sex workers should be integrated into all sub-projects that work with CSWs. This should be complemented with special training exercises with the implementing NGOs on how to best intervene with child sex workers.

3.6 Policy Issues

Findings

Risk behavior for many of the ASEP target "groups" is being facilitated by structural and environmental factors that limit individuals who do wish to use condoms during sexual contact. Thus, while the individual level interventions supported by ASEP may raise desire for risk reduction behaviors, the environment does not always allow for individual choice to be acted upon. For example, many sex establishment managers ("mama sans", floor managers, pimps, etc.) are known to discourage condom usage due to concern over lost profits. Thus, when customers refuse to use a condom, the sex worker has little capacity to refund the money paid and refuse sex. In the current system, incident STD in sex establishments among sex workers is not associated with follow-up by public health personnel, nor with sanctions targeted to sex establishment owners to create incentives for them to mandate condom use in their establishments. Many sex workers have few alternatives to sex work for survival. Since prostitution is illegal, but tacitly allowed (and in fact regulated and taxed), sex workers have little legal/police protection and recourse from violent and abusive clients who may refuse to use condoms or rape them.

Conclusions

There are many structural and environmental impediments to behavior change among the target groups. Environmental and policy interventions are needed to assure that the complementary individual risk reduction interventions are effective. There are some pragmatic environmental and policy changes that could be made that would likely have a significant impact on the success of risk reduction interventions. Identification of environmental and policy

issues should be based on careful analysis of the options, and a strategic plan should be developed in consultation with USAID and the Philippines DOH.

Recommendations

- Develop a policy program with a dedicated person who will: a) conduct research and analysis of key policy issues, b) develop and deliver policy presentations, c) advocate for policy changes, and d) train NGOs to conduct policy advocacy.
- Key policy issues include: a) viability of sanitation code targeting CSWs and STD; b) syphilis epidemic and lack of diagnosis and treatment; c) quality of services at social hygiene clinics; d) financial support for prevention activities; e) tax opportunities to support Social Hygiene Clinics and HIV/STD prevention; f) LGU purchases of STD drugs; g) legal and human rights protection of CSWs, MSMs, and IDUs; h) 100% condom policies; i) identification and promotion of structural and environmental interventions for each target group/location; and j) legal suppression of child sex work and legal prosecution of rape and abuse of CSWs.

3.7 Miscellaneous Issues:

3.7.1 STDs

Findings: There continues to be a serious shortage of STD drugs available to high risk populations. Likewise, there is almost no capacity to diagnose syphilis, and sentinel surveillance has identified epidemic rates of syphilis among some of the ASEP target groups. PATH has continued to train a wide variety of health care professionals on the syndromic management of STD. Despite these attempts, the Social Hygiene Clinics continue to diagnosis *Neisseria gonorrhea* (GC) through gram stains, and the drugs required to treat incident STD are not available. Moreover, it appears that there is widespread use of antibiotics for prophylaxis of STD by sex workers, and Ciprofloxacin resistant GC is common.

Recommendations:

- PATH should continue to train health care providers in syndromic management of STDs.
- Policy activities should be undertaken to improve the supply of STD drugs at public facilities, the capacity to diagnosis and treat syphilis, and the use of syndromic diagnosis and treatment of STDs.
- If funds are available, it would be useful to conduct basic studies of antibiotic resistance of STDs, and the effectiveness of syndromic management of STD in the Philippines setting.

3.7.2 Condoms

Findings: Condoms are currently socially marketed under the "Trust" brand name to high risk groups by DKT through use of special incentives to the sales force. Availability and affordability of high quality socially marketed condoms are good in the Philippines. USAID has also donated

a large supply of generic condoms which is being distributed through the public sector for family planning.

Recommendations:

- USAID support of DKT to provide socially marketed condoms to special and hard to reach groups should be continued.

SECTION 4: ORGANIZATIONAL ISSUES

4.1 Institutional Support

Findings

A network of government and non-government agencies and institutions already exists for work on STD/HIV/AIDS prevention and control.

On December 3, 1992, Executive Order (EO) 39 was passed by President Fidel V. Ramos creating the Philippine National AIDS Council (PNAC) as a national policy and advisory body in the prevention and control of HIV infection and AIDS in the country. Chaired by the secretary of health, the PNAC has as its members representatives of the Departments of Education, Culture and Sports; Labor and Employment; Justice; Tourism; Local Government; Budget and Management; Social Welfare and Development; and Foreign Affairs and NGOs, private volunteer groups, professional associations, advocacy groups, and other interested parties. The PNAC is mandated to advise the president. Its policy guidelines are expected to be reflected and implemented in all operational activities throughout the country through the DOH as well as the LGUs with NGOs as support. An EU-funded project is looking at the establishment of a PNAC counterpart in six local government units.

A Technical Working Group (TWG) was created by PNAC to provide technical support for its policy and program formulation. Most of the members of the TWG come from the same agencies/institutions represented at PNAC, but at a lower organizational level. They prepare the working papers for decisions made by PNAC, such as the IEC Checklist and Guidelines on HIV/AIDS materials, the HIV/AIDS strategy document, and implementing guidelines for EO 39.

Lack of commitment of some of the government agencies to both PNAC and TWG has been noted. Usually representatives to the bimonthly PNAC and monthly TWG meetings change, requiring continuing orientation and slowing down work. Lack of funding for a permanent secretariat for the two groups as well as for meetings has also been pointed out. The development of an AusAID-WHO funded Philippine National HIV/AIDS strategy is considered an accomplishment of the PNAC. In 1997, it will focus on policies around labor laws and health rights of workers.

The National AIDS Advisory Committee (NAAC) within the Department of Health, brings together the different services involved in STD/HIV/AIDS: RITM, BRL, San Lazaro Hospital, FETP, PIHES, HMDTS, and the STD/HIV/AIDS Unit. The NAAC is supposed to meet once every two months.

In 1988 the HIV/AIDS unit was created to carry out the National AIDS Prevention and Control Program (NAPCP) and implement the first medium term plan under the auspices of the undersecretary for public health services. In 1993, the program became known as NASPCP when Secretary Juan Flavio Velasco integrated STD into the program and transferred the unit to the office of special concerns. A second medium term plan was put into place in 1994. Within the DOH, this unit is the focal point for STD/HIV/AIDS work as the mandated program manager for NASPCP, convenor of donor community meetings, and secretariat for the PNAC, TWG, NAAC

and National STD Technical Committee (NSTC). It serves as a center of information, skills, training, policy development, advocacy and support for those affected.

Although the program has existed for close to nine years, the STD/HIV/AIDS unit has not been institutionalized in terms of a unit with a regular plantilla that can seek budgetary allocations for salaries. At the moment, the unit has seven regular staff seconded from other DOH offices and programs and eighteen contractual staff. Together with other 1997 priority projects (Maternal Child Health, Family Planning, Dental Health and Nutrition), the STD/HIV/AIDS Unit is under the direction of an Assistant Secretary who reports directly to the Office of the Secretary (as of 2/3/97). Whether and when it will be institutionalized will be decided in conjunction with the bill to reorganize the DOH that is currently expected to be submitted to the legislature in April 1997.

At the regional level, program management is still within the purview of the DOH, through a regional coordinator who acts as program manager for the region, receiving monthly reports from the LGUs in his/her region and submitting them to the central office on a quarterly basis. At the LGU level where health services are now delivered with the implementation of the Local Government Code, the STD/HIV/AIDS program is run by the City or Provincial Health Offices through their respective social hygiene clinics.

The link of DOH with the implementing LGUs remains tenuous. All communications and dealings go through the regional coordinators who are responsible for other programs. Some LGUs have not been very diligent in submitting reports to their regional coordinators. In the 1997 NASPCP schedule of activities prepared by the DOH STD/HIV/AIDS unit, the meetings are at national (PNAC, PNAC-TWG), central (NAAC), or regional levels; no meetings with local government units are included.

To date, the mechanisms that are supposed to link DOH and LGUs are the Comprehensive Health Care Agreement (CHCA) and representation of a DOH person in the LGU Health Board. Both mechanisms are still evolving. The CHCA is a contract entered into by the DOH and the LGU that detail their respective counterparts for major activities (service delivery, logistics/equipment, training, IEC, monitoring and evaluation) supporting DOH program targets. For the STD/HIV/AIDS program, DOH support usually consists of STD drugs and reagents, and is based on the reports submitted by the LGUs to their regional coordinators. The LGUs visited reported the inadequacy of STD drugs and reagents coming from the DOH which was confirmed by the STD/HIV/AIDS unit.

At least twenty local NGOs that have started or intensified work in STD/HIV/AIDS because of the ASEP-PATH education component. The list includes Bidlisiw, Cebu Youth Center, Community Health and Development, Inc., Fellowship for Organizing Endeavors, Foundation for Adolescent Development, Free Legal Assistance Volunteers Association, Institute for Social Studies and Action, Kabalikang Pamilyang Pilipino, League of Angeles City Entertainers and Managers Association, Mahintana Foundation, Mindanao State University Foundation, ReachOut, Social Action for Life's Upliftment, TriDev, and University of Southern Philippines Foundation.

On an even broader scale, a senate bill authored by Senator Freddie Webb and consolidating six bills and two resolutions proposing various measures to address the problems of AIDS, was approved by the Committee on Health during the Ninth Congress. Called the Philippine AIDS

Prevention and Control Act of 1995, it creates a Philippine AIDS Prevention and Control Commission, institutes a nationwide AIDS information and education program, and establishes a comprehensive AIDS monitoring system. It has not yet reached third hearing and is scheduled to be presented again at the next congress.

Conclusions /Recommendations

The agencies and institutions involved in STD/HIV/AIDS work vary not only in terms of role and coverage, but also in their level of resources as well as commitment. Some efforts, in particular donor support, are already in place to strengthen individual organizations such as the PNAC and its supporting TWG. Institutionalizing of the STD/HIV/AIDS unit within the DOH is now lodged within a legislative process and should take place in due time. The linkage mechanisms between the DOH and the LGUs for DOH programs will also take some time to work out.

ASEP must focus organizationally on the local government unit level because this is the level now responsible for delivering health care services. The Local Government Code has given the LGU both governance and financial autonomy to support and perform the education and surveillance activities of the project. In fact, the first three years of ASEP has produced examples of and lessons on how the LGU can undertake STD/HIV prevention and control programs.

4.2 LGU/NGO Networks

Findings

ASEP has catalyzed various models of LGU/NGO networks for STD/HIV/AIDS. In general, these link together the health office, the social hygiene clinic, other local government offices, private organizations, and NGOs. Networks are most successful when they gain political will and support, and when the partners bring complementary skills and resources to the relationship.

Quezon City has a Quezon City AIDS Task Force created by the mayor through an executive order and reporting directly to him. One of its councilors successfully supported budget appropriations for meetings and IEC requirements of the AIDS Task Force. Health certificates are issued only when applicants have complete STD/HIV/AIDS training. This is conducted with the help of NGOs that are considering charging training fees. The Task Force acknowledges the work done by NGOs to access high risk behavior groups that government offices cannot.

General Santos City formed an STD-AIDS Council through an executive order. Orchestrated by the social hygiene clinic, the Council tracks all activities and funding of STD/HIV/AIDS control and prevention. It has started to talk about earmarking of taxes and fees paid by commercial sex workers and establishments as a source of funds. The city council seems well aware that it needs a good health record for all its residents to push its bid for more investment.

Cebu City included its work on STD/HIV/AIDS in its Basic Urban Health Services Task Force and has set up a Technical Advisory Council as well. The Council holds quarterly meetings

attended by NGOs working on STD/HIV/AIDS and various local government offices, including the police department. The NGOs appreciate the recognition given to their work by the city officials and through it, their access to resources as well as to a wider network.

Conclusions /Recommendations

While these networks provide models, the work on LGU-NGO collaboration in STD/HIV/AIDS control and prevention has just begun. ASEP should continue the focus, strengthening existing linkages and exploring new modes for other LGUs.

To further STD/HIV/AIDS control and prevention, ASEP technical assistance for LGUs/NGOs must support:

- creation of networks that are eventually made official by the LGU;
- financial sustainability measures to fund NGO programs and local government health services related to STD/HIV prevention and control need to be explored; these include examining opportunities for user fees, insurance schemes, training fees, establishment of taxes, health certificate fees, earmarking of health budgetary appropriations, to creation of health trust/revolving funds;
- implementing guidelines for the Sanitation Code of 1976 at the LGU level especially with respect to the requirements, enforcement, and penalties of health certificates for employees of food establishments, dancing schools, dance halls and night clubs, tonsorial and beauty establishments, and massage clinics and sauna bath establishments;
- creation of public/private partnerships; and
- capacity building of NGOs and LGUs.

4.3 Coordination between Surveillance and Education Components

Findings

According to the mid-term evaluation, the education and surveillance components were implemented separately in the initial phase of the project. Eventually a steering committee was established to provide project oversight as well as coordinate the two components. The committee apparently did not work too well because the mid-term evaluation proceeded to recommend its reactivation.

Coordination between the surveillance and education components of ASEP continues to be weak. FETP, PATH, the NGOs and the LGUs indicated that meetings are usually held after every surveillance round to disseminate as well as discuss findings. But coordination can be more substantial than just sharing information and discussion. The incorporation of behavioral surveillance in sentinel surveillance and development of the BSS could have benefited from more interaction between FETP and PATH. Data collection instruments used by FETP should

complement and mesh with the program monitoring carried out by PATH's network of NGOs in the surveillance sites. At present, such complementarity of data and results does not exist. The STD/HIV/AIDS program manager also expressed her interest in being part of ASEP and having more access to its activities.

Conclusions /Recommendations

ASEP needs a working steering committee that will bring together the surveillance and education components as well as the STD/HIV/AIDS program management. The surveillance and education components can learn and help each other in many aspects of the project, such as monitoring and evaluation, identification of "target groups," developing "target group"-specific messages, generating and analyzing feedback on behavior change.

The active involvement of the STD/HIV/AIDS program management is important. Through that unit, formulation of policies culled from ASEP experience can be initiated since it serves as secretariat to the policy making institutions for STD/HIV/AIDS. At the same time, while the linkage between DOH program management and the implementing arm of the LGUs is still being defined at the CHCA and local health board representation levels, the steering committee will provide the STD/HIV/AIDS unit a window to activities at the LGUs covered by ASEP. Moreover, the unit may be able to identify funding for other projects related to but not supported by ASEP since it convenes and manages donor meetings for STD/HIV/AIDS.

The steering committee should be designed such that it becomes a real working committee, not just another layer to hurdle in terms of approvals to get ASEP activities going.

4.4 National Voluntary Blood Donation Program

Findings

A USAID-funded field survey of the country's blood banks from September 1993 to January 1994 led the DOH to take steps to more carefully monitor blood banking activities and address shortcomings with policy and regulatory changes to ensure the safety of blood supply. Specifically, Republic Act 7719 or the National Blood Services Act was passed on April 28, 1994 establishing a National Voluntary Blood Services Program (NVBSP). It set a timetable of two to four years to close the country's commercial blood banks.

Implementing rules and regulations were drafted and adopted on April 28, 1995. These clearly delineate the parameters of the NVBSP and place authority within the Office for Hospital, Facilities, Standards, and Regulation (OHFSR) in DOH. The ASEP project funded subsequent activities: a conceptual framework and plan for the development of the NVBSP; a five-year strategic plan covering its programmatic, communication, training and investment plans; a detailed implementation plan; and technical assistance to carry out the implementation plan. To date, only one KAP study has not been submitted to complete all these activities.

The five year strategic plan was officially accepted and endorsed by the Secretary of Health in October 1996. In January 1997 a meeting of the National Program Committee, the overall

policy making and program planning body of the NVBSP was held to discuss the implementation of the strategic plan.

Conclusions /Recommendations

By February 15, 1997, the KAP study will be submitted, completing all the outputs for the USAID grant. Together with RA 7719 with its Implementing Rules and Regulations, and the 1996 Manual of Standards for Blood Banks and Blood Centers, these outputs should be adequate for the DOH to begin implementation of the strategic plan.

Since the focus of ASEP assistance is surveillance and education, DOH will have to source funds from other donors or sources for the implementation.

4.5 Donor Funding

Findings

Services in the Office of Public Health Services, such as Family Planning and Maternal and Child Health, have recognized that donors' meetings are effective in generating, allocating, coordinating, and monitoring donor funding for its priority projects. The second medium term plan for the STD/HIV/AIDS unit advocates for formal communication channels between donor agencies and the NASPCP through quarterly meetings and the continued involvement of donors in the program.

However, these meetings have not been held regularly perhaps because of changes in the unit's management. Last year, two meetings were held in the last semester. In October 1996, the STD/HIV/AIDS unit presented its priorities to the donor community. In December 1996, it presented proposals seeking funding support. During one of the meetings, the donors recognized the inadequate supply of STD drugs and JICA offered to bring in some drugs. For 1997, the STD/HIV/AIDS program manager has indicated her plan to make more effective and regular use of these meetings.

The 1996 foreign-assisted projects of NASPCP counted AusAID, EU, JICA, SEAMEO-TROPMED, UNAIDS, UNDP, UNFPA, UNICEF, USAID, and WHO. USAID was and continues to be the largest donor. Donor funding goes into surveillance, education, research and planning, technical assistance, support for PNAC at the national and LGU levels, establishment of STD clinics and a central laboratory, syndromic management, and information systems. The NASPCP is also able to secure resources from projects such as the Urban Health and Nutrition Project and the Women's Health and Safe Motherhood Project.

Conclusions /Recommendations

The STD/HIV/AIDS program manager intends to hold donors' meetings regularly starting 1997. ASEP must support and participate in these meetings to avoid duplication among the various donors and help in the successful and more cost-effective implementation of NASPCP.

SECTION 5: FINANCIAL SUSTAINABILITY

Findings

The recommendations made in the preceding sections indicate how important it is to continue surveillance and education activities in response to the presence of HIV infection and AIDS cases in the Philippines. As long as the disease is present, while effective and affordable medical treatment for infection are not available to the general public, surveillance and education for prevention and control are needed.

At present, the costs of ASEP activities are not excessive. The cost for one round of surveillance per site for the six high-risk groups is approximately \$20,000. For ten sites with two surveillance rounds per, the annual cost is approximately \$400,000. However, by implementing recommendations made in Section 2, surveillance costs should decrease substantially as the number of sites is reduced to no more than eight, surveillance rounds are conducted only once a year and fewer high-risk groups are routinely included in the surveillance rounds. With these changes, surveillance costs could fall to \$200,000 annually even with additional special studies and greater use of external surveillance experts as recommended.

Over the course of ASEP, expenditures for education activities have increased as new programs are initiated in additional cities. If education programs are supported in a maximum of eight surveillance sites/cities, annual program support would reach approximately \$2 million. While ASEP activity costs are far from exorbitant, they exceed the DOH's total annual budget for STD/HIV-related activities, which in 1996 was roughly \$1.6 million. Looking to the DOH to absorb all or most of the costs of ASEP-supported activities would require a doubling of the current annual budget for STD/HIV activities.

Local governments, including the major cities where STD/HIV infections are most prevalent, face equally severe budget constraints. Devolution has increased national budget allocations to local governments and expanding local taxing authorities with retention of tax revenues at the local level. However, local governments argue that budget allocations from the national level are insufficient and that they have not been increased in proportion to the expanded responsibilities local governments now have for providing public services.

Lobbying for higher priority for STD/HIV activities and increased budget allocations at the national and local levels of government is a standard response. This is certainly a worthwhile possibility to explore, but given the budget limitations governments confront, increases are likely to be small, if they made at all. There are simply too many competing priorities for existing government resources to expect substantial increases in budgets for STD/HIV-related activities. Moreover, these are not politically popular activities when outlays for such programs mean less funds for government services which have broader public support, such as new schools and roads.

The present situation with respect to the country's growing STD problem illustrates perfectly the lack of government resources for health services. While the spread of STDs is widely recognized and the connection between STDs and HIV infection is understood, treatment for STDs, particularly syphilis, is woefully inadequate in public facilities. While the introduction of syndromic management of STDs is a major improvement, the DOH and local governments are

not procuring sufficient quantities of drugs to respond effectively to the problem. An almost universal response from health service providers was that they lack drug supplies for treatment. Allocations to the regional DOH were reported in one city as never reaching them; supplies are so limited that the Regional Health Office provides STD drugs only to the major city in the region.

While current government revenues might be too constrained to permit a substantial increase in funding for STD/HIV-related activities, an alternative is to look for new revenue sources which could help to cover all or at least a major portion of the costs of such services. In light of devolution and increased taxing authorities at the local level, the most promising point for identifying and collecting these revenues seems to be at the local government level, specifically, city governments. The cities are the unit of government which will have to deliver actual services through Social Hygiene Clinics and other health facilities, as well support future education programs conducted by local NGOs.

One possibility the Assessment Team explored with local government officials is an "entertainment tax" on establishments employing commercial sex workers. Analogous to licenses businesses must purchase each year to sell food, alcohol and tobacco, commercial sex establishments (e.g., bars, karaokes, massage parlors) would be required to obtain an additional special entertainment license. These establishments are the profit centers in the commercial sex industry. The cost of the license could be made proportional to the past year reported revenues as stated in tax returns, or it could be imposed as a "head-tax" on the number of CSWs working in the establishment. The revenues generated from an entertainment license could be used to finance local HIV and behavioral surveillance, STD diagnosis and treatment (i.e., drugs), Social Hygiene Clinic operational costs and educational programs conducted by local NGOs. In effect, this tax would be placed on the establishments which profit most from the commercial sex industry and which contribute to the health and social problems resulting from this activity.

The Assessment Team learned that General Santos City already imposes such a tax - P600 per entertainer. However, these funds are not currently being allocated to fund STD/HIV-related activities. Other city officials expressed interest in this possibility and identified several hurdles which would have to be overcome, such as the legality of such a license given the current local tax code. City governments would also need to establishing budget earmarks which would assure that revenues from an entertainment license would be allocated to STD/HIV-related activities. Officials might also need external assistance in developing strategies and public information campaigns which would make the delivery of such services acceptable to the general public, e.g., we are responding to the local STD/HIV problem, these services benefit the entire community and are being financed by a tax on the establishments which profit most from the commercial sex trade.

Imposition of an entertainment tax will require some intestinal fortitude on the part of local government officials. However, this will be more likely found at the local city level of government than higher up. Moreover, local officials have better knowledge about who the owners are of these establishments, as well as the political muscle to impose such a tax.

Other financing options might also be possible, such the collection of fees for services and commodities by Social Hygiene Clinics or other public health facilities which treat STDs. Some

NGOs have tried selling condoms to generate revenue, and one NGO the Assessment Team visited is considering charging fees for seminars or workshops to finance its work with peer educators. In Angeles City, the League of Angeles City Entertainers and Managers Association uses part of its membership fees for an insurance fund for health care expenses. Quezon City allocated funds for meetings and IEC requirements for its AIDS Task Force. In short, LGUs and NGOs are already exploring financing mechanisms to support STD/HIV-related programs and services.

Conclusions

In light of the budget austerities the GOP faces in the immediate future, combined with the multitude of competing priorities for limited government resources which policy makers are likely to view as more urgent or important than expenditures for STD/HIV programs, it is unrealistic to expect significant increases in the DOH's budget for these activities after ASEP assistance ends. Though local government budgets are also very constrained, there is a greater possibility for city governments to finance surveillance and education activities started by ASEP.

City governments and NGOs could benefit from various types of assistance in developing revenue generating mechanisms to fund and budget for STD/HIV-related programs. During the three year extension of ASEP, technical assistance should be provided to cities and NGOs interested in exploring financing possibilities for STD/HIV programs.

Recommendations

ASEP should fund technical assistance to develop and disseminate financing mechanisms for STD/HIV activities by local governments and NGOs. The feasibility of incorporating this assistance into the PATH Cooperative Agreement should be explored. Alternatively, field support funds could be provided to the new USAID/Washington central cooperative agreement if it has a strong policy/financing capacity building component.

SECTION 6: ASEP MANAGEMENT ARRANGEMENTS

ASEP activities are funded through two mechanisms: a grant to WHO for surveillance activities and a Cooperative Agreement with PATH for education activities. This section briefly discusses the future use of these arrangements for the extension of ASEP.

6.1 The PATH Cooperative Agreement for Education

The Cooperative Agreement (CA) with PATH was established in September 1993 and specified that PATH would undertake support in four surveillance sites/cities (actually stated as “up to four sites”). In the initial CA, USAID stipulated that PATH would work through local “partner” NGOs which would serve as an intermediary between PATH and the local NGOs which would actually implement education programs for selected high-risk groups. The purpose of this “three-tiered” was to foster institutional capacity building within the partner NGOs to develop local organizations capable of assuming the planning, management, technical oversight and financial administration functions PATH currently performs under the CA. This arrangement was also expected to augment PATH’s limited staffing capabilities as the number of local NGO programs increased over time. PATH responded to these directions by establishing sub-agreements with Kabalikat, RAFI and ALAGAD.

By the time of the 1995 Mid-term evaluation, this “three-tiered” arrangement was not working smoothly. In brief, the evaluation recommended clarifying the roles and responsibilities between PATH and its partners. Differences in policy and program orientation, as well as the level effort expected by both parties of these sub-agreements strained working relationships. PATH terminated its agreements with RAFI and ALAGAD and worked directly with local NGOs in the Visayas and Mindanao regions. At the time of this Assessment, some 20 direct agreements with local NGOs were being implemented, others had recently terminated and some were planning to obtain further funding from PATH for subsequent programs. It should be recognized that the identifying and supporting more than 20 local NGOs to undertake these programs is an accomplishment in and of itself. It was not certain that sufficient numbers of local NGOs would be interested and capable of participating in ASEP. This constitutes a key element in developing local capacity to implement STD/HIV-related programs. The next step will be to improve the effectiveness of individual programs which is currently underway.

The Assessment Team had numerous opportunities to observe various examples and elements of PATH’s performance with respect to fulfilling its responsibilities under the Cooperative Agreement. Overall, PATH has done an extremely sound job with what was initially expected to be a very difficult task. At the time of ASEP’s design in 1992, it was not clear that a sufficient number of local NGOs could be identified, let alone be able, to implement effective education activities in a number of cities throughout the country. The extent to which local NGOs depended on PATH for programmatic and operational support varies, but it was clear to the team that a number of these NGOs would not have been able to undertake STD/HIV-related education programs without PATH’s assistance. This reflects the high professional caliber and skills of the individuals PATH has fielded under this CA. The Assessment Team also had the opportunity to observe very collegial relationships between PATH’s professional staff and the NGO and local government staff with whom they work. The Team found no evidence or example of a NGO program failing or suffering because of a poor working relationship. This is all the more striking in light of the potentially contentious issues or problems that could arise

between PATH and its client NGOs. However, it does appear that PATH's current staffing level is reaching its limits as additional sites/cities have been added; further expansion of programs and/or functions without additional personnel could result in deterioration of PATH's past high standard of performance.

PATH has been highly responsive to meeting the terms of amendments to the original CA for additional activities - i.e., the Phil-Thai Exchange Program, the National Voluntary Blood Bank Strategy, and the development and dissemination through training at the service delivery level of the STD Syndromic Treatment approach. PATH has also facilitated information sharing and exchange of experiences/lessons learned effectively through meetings and workshops sponsored by it. Activity planning and documentation, such as strategic planning of the Education Component and periodic reporting, meets sound professional standards.

While PATH's incorporation of program monitoring requirements in sub-grantee agreements is laudable, and recognizing that considerable effort was directed to assuring such data are collected and analyzed, better selection of monitoring indicators more appropriate for the stage of NGO program development and better coordination with FETP on the BSS would have improved the utility of this monitoring. (Lack of coordination on the BSS is principally a problem FETP must address, but PATH is also responsible for assuring better coordination in the area of behavioral data collection). The failure of the "three-tiered" arrangement is a moot point now - the underlying problem of poor working relations is probably best characterized as a result of good intentions gone awry from all parties involved. PATH quite correctly has emphasized institutional strengthening at the LGU-NGO level which is far more likely to result in effective programs and sustainability of activities than original directions to focus on higher organizational or administrative levels.

Conclusions

PATH has clearly demonstrated a high level of performance in all key areas of the Education Component for which it was responsible. There is no apparent need for an intermediary partner NGO arrangement; PATH is clearly capable and now experienced in working directly with local NGOs. This should be the approach followed in the extension of ASEP. There is no technical reason to open the extension of ASEP's Education Component to alternative organizations. This would only result in an undesirable, prolonged interruption of on-going programs, as well as a loss of experienced personnel from the PATH team. PATH needs to consider adding at least one more program specialist to assure sound management and supervision of new, additional NGO programs. The PATH CA seems a logical means for supporting the policy and sustainability activities recommended in preceding sections. However, this issue needs further review to determine whether PATH is an appropriate organization to undertake these activities, what additional staffing would be required and whether PATH can access individuals with the appropriate technical skills for this work. Alternative mechanisms, such as the cooperative agreements to be let under the Global Bureau's recently approved HIV/AIDS Strategic Objective, should also be considered.

Recommendations

- USAID and the DOH should extend the existing Cooperative Agreement with PATH to September 30, 2000, and add sufficient funding to support operations in up to eight cities.
- The "three-tiered" structure should be eliminated, including the agreement with Kabalikat; PATH should work directly with local NGOs, focusing on improving program effectiveness and strengthening the LGU-NGO relationship for institutional capacity building.
- PATH needs to add one full-time professional staff position to assure adequate support of NGO programs, especially in the areas of monitoring, training and evaluation.
- The feasibility of expanding the CA to include the policy and sustainability assistance recommended in preceding sections needs to be reviewed more thoroughly before this is incorporated into the PATH CA extension. At a minimum, PATH will need one full-time professional staff person to support these additional functions and budget for short-term technical assistance to implement these activities. Alternatively, policy and sustainability technical assistance may be obtained from the USAID/Washington new cooperative agreement.

6.2 The WHO Grant for Surveillance

Findings

ASEP's funding for surveillance activities is provided through a grant to the World Health Organization's (WHO) Regional Office of the Western Pacific which is located in Manila. WHO's Global Program for AIDS (GPA) offered a suitable mechanism for ASEP's surveillance support. Under the terms of the grant agreement WHO would provide technical, administrative and logistical support for the development and operation of the HIV Sentinel Surveillance system (HSS) and, subsequently, for the Behavioral Surveillance System (BSS). WHO had an established working relationship with the DOH's FETP which is responsible for both the HSS and BSS. The GPA funded a long-term AIDS advisor assigned to the Philippines who provided effective administrative and oversight support through 1995. Technical support for the development and implementation of the HSS was actually provided by long-term technical advisor from the U.S. Center for Disease Control funded by USAID/Philippines to provide assistance to FETP. WHO entered into a sub-agreement with the New Tropical Medicine Foundation (NTMF) to administer funds for financing HSS field operations, i.e., payment to cities for staff costs to conduct the HSS rounds. This arrangement is reported to be working well. After some initial difficulties, procedures were established by WHO and FETP to assure a smooth flow of funds. In addition to surveillance field operations, the WHO grant also finances the purchase of reagents for testing; central FETP support for the surveillance systems (e.g., office equipment, travel budgets); two contract staff positions for the STD/HIV/AIDS Unit; two contract staff positions in FETP; local training and international conference costs; and short-term technical assistance.

WHO began to experience difficulties in meeting its responsibilities under the terms of the agreement for adequate technical and management oversight because of the termination of the GPA in December 1995. WHO lost its full-time AIDS advisor who had been funded by the GPA. WHO's own budget is too limited to cover the costs of this position. By mid-1996,

management of ASEP had been assigned to WHO staff who have regional responsibilities, meaning that their involvement with ASEP's surveillance activities is currently on a part-time basis. By the end of 1996, WHO officials report that they had determined that surveillance activities needed greater attention. WHO has recently proposed to USAID that ASEP fund 50 percent of a contract staff position to meet the technical and management oversight requirements of the surveillance component. In effect, ASEP would be funding an advisor for WHO to meet its responsibilities under the terms of the grant agreement. This would be in addition to the 13 percent administrative costs WHO obtains from the grant to cover administrative costs for managing the grant.

Available budget data for the Surveillance Component suggest that, in light of the recommendations to reduce the scope, coverage and frequency of HIV surveillance, current funding committed to the WHO grant might be sufficient to support surveillance work for the next several years and possibly until the end of ASEP assistance in September 2000.

Conclusions

Up until 1996, the technical and administrative requirements for the surveillance component were being adequately met through the WHO/GPA advisor with technical support from the USAID-funded CDC advisor. Since then, WHO's ability to meet its administrative and technical responsibilities have been substantially diminished. The proposal to create a position to meet these responsibilities using ASEP funds seems contradictory to the fact that WHO collects a 20% administrative fee for oversight of ASEP surveillance activities and funds.

WHO's assessment that greater attention to technical aspects of the HSS is needed to improve data quality was probably more urgent when the plan was to expand to additional surveillance sites. With the retrenchment in the number of sites, the number of high-risk "groups" needed for routine surveillance and the frequency of HSS rounds recommended by this assessment, the need for substantial technical involvement by WHO needs to be re-examined. Conversely, the recommendations to improve and rationalize the various behavioral surveillance and monitoring activities supported by ASEP identifies an important area which requires considerably greater technical input and oversight. External expertise is needed to accelerate the development of data collection instruments for BSS and NGO monitoring and assure complementarity of efforts, which is currently lacking. It is not clear that the WHO proposal is the most effective way to accomplish this.

In light of the recommendations to reduce the scope and frequency of HIV surveillance, the costs of future surveillance activities needs to be estimated. A multi-year workplan covering the three year extension period should be developed for the revised HSS, an expanded and improved BSS and related special studies, including annual budget projections.

Recommendations

- The recommendations of this assessment should guide planning for additional technical and administrative assistance for the surveillance activities of ASEP. FETP, USAID and WHO should reach agreement on the specific types of technical assistance required; the level of WHO oversight of, or direct involvement in, surveillance activities; and the most cost-effective

mechanisms for procuring this assistance, making full use of funds in the WHO grant available for these purposes.

- ASEP grant funds should not be used for a long-term contract position to provide technical guidance; rather, technical guidance should be obtained on a short-term, as-needed basis using external consultants who have worked on similar issues and problems in other STD/HIV/AIDS programs in the Asia/Pacific Region.

- Given WHO's budget constraints which affect its ability to meet the terms of the grant agreement, limited ASEP funding (e.g., 10-20 percent of a full-time position) might be used to enable WHO to meet its administrative requirements over the short-term. If WHO continues to be unable to meet its grant responsibilities, USAID should consider alternative financing arrangements for supporting surveillance activities.

- An extended workplan should be prepared, reflecting the Assessment's recommendations for surveillance, including annual budget estimates. To the extent possible, planned activities over the next three fiscal years should be accommodated to the balance of funds remaining in the WHO grant. No additional funds should be committed to surveillance unless absolutely necessary.

6.3 USAID's Results Framework for the HIV/AIDS Special Objective

As an outcome of USAID's re-engineering of program management systems, ASEP activities support the achievement of the Special Objective to prevent a rapid increase in HIV/AIDS infection in the Philippines. The recommendations of the Assessment Team lead to a number of modifications in indicators and targets at the Objective, Intermediate Result and Activity levels. For example, the current indicator for the Special Objective is "HIV seroprevalence rate among target risk "groups" remains less than one percent in 2000." Given that HIV prevalence already exceeds one percent for CSWs in Angeles City and that high-risk behaviors are so widespread among target "groups", it will be very difficult, if not impossible to keep prevalence rates below one percent within these "groups" over the 5-10 years. The indicators could also be refined to focus on female CSWs since this is the largest high-risk "group" and has the greatest potential for transmitting HIV infection to a large percentage of their sex partners.

At the intermediate result level, the currently stated result concentrates solely on prevention practices. Several key steps typically precede adoption of prevention practices, such as an increased understanding and knowledge about HIV infection, recognition of personal risk, formation of attitudes and motivation to make behavioral changes which will reduce potential exposure to infection. Much of the on-going NGO programs are directed toward such intermediate changes which will lead to lasting behavioral changes. This suggests modifying the Intermediate Result to include knowledge, perception and attitudinal changes as important program results. This also suggests the need for an additional set of indicators at the Intermediate Result level which capture these interim steps that lead to adoption of risk-reduction behaviors.

Condom usage targets also need to be increased if the results obtained are to be epidemiologically significant. As the report has noted, the BSS and NGO monitoring systems

need to be improved and coordinated to assure that meaningful and useful data about condom usage are being collected. The syphilis seroprevalence rate, current targeted to decrease by 2000 needs revision in light of: a) the current high rates of syphilis found among certain high-risk "groups", and b) the lack of adequate drug supplies for treatment. At the Activity level, the number of HSS and BSS sites currently targeted for 20 and 16 respectively. The recommendations from Section 2 reduce both HSS and BSS activities to 6-8 sites/cities. Moreover, a better indicator of the operation of the HSS and BSS is evidence that data are being generated and used by the DOH, the local governments and NGO's for their on-going programs. The number of peer educators and outreach workers trained, sex establishments reached, and health care providers trained need to be reviewed in light of the extension of ASEP activities and the recommended expansion of education activities.

Conclusion

Some of the current indicators, baseline measures and estimated targets used in the Results Framework for the HIV/AIDS Special Objective need to be revised to improve the validity of these measures of program results.

Recommendations

- USAID needs to review and modify indicators, data sources and collection instruments, baselines and targets as needed in light of current infection rates among high-risk groups and programmatic changes recommended by the Assessment.
- USAID should consider expanding the Intermediate Result to reflect important knowledge and motivational changes being promoted by NGO education programs.

**ANNEX 1: STATEMENT OF WORK - SPECIAL OBJECTIVE: RAPID INCREASE
OF HIV/AIDS PREVENTED ASSESSMENT/AMENDMENT TEAM SERVICES**

I. Objective of the Services

An assessment/amendment team is being contracted under the Mission's Special Objective (SpO), Rapid Increase of HIV/AIDS Prevented. The objective of this Scope of Work is to: 1) provide assistance in the process of refining the activities to occur in the SpO 1998-2000 period; and (2) assist in the preparation of the revision of the SpO Results Framework and other documentation needed for the 1998-2000 period.

Most activities have been running for more than three years; however, given the length of time since the original project was designed, it is time to take a look at the planned activities and assumptions and decide whether we should continue on the same course, continue but make mid-course adjustments, or completely change our approach for 1998-2000. (Current activities are funded through September, 1998.)

The assessment members will work as a team. The team is responsible for providing the following inputs for SpO Results Framework revision for the 1998-2000 period:

1. Review/assess the implementation of the National HIV sentinel surveillance systems and recommend actions to improve their effectiveness and ensure sustainability.
2. Review/assess the basic elements and mix of primary and secondary prevention activities implemented under the SpO and recommend program design modifications to maximize their effectiveness and to make them more responsive to the current and future course of the HIV/AIDS epidemic.
3. Review and assess program administrative and management structures and recommend appropriate changes.
4. Assess Local Government Unit (LGU)/non-government organization (NGO) participation in STD/HIV/AIDS surveillance and prevention activities; identify strategies that need to be employed to strengthen LGU capabilities to manage HIV/AIDS prevention programs.
5. Review implementation mechanisms and make recommendations on whether to continue with current existing grant with the WHO for surveillance and cooperative agreement with the PATH-Philippines for IEC activities.
6. Assess the importance and contribution to the overall national program of the USAID centrally funded AIDSCAP project and other donor efforts focused on STD/HIV/AIDS control.

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7. Recommend to the Government of the Philippines (GOP), particularly the Department of Health, and to donors on how the national program can enhance its achievements and how to make the program more effective and efficient in controlling the spread of HIV and other STDs in the Philippines.
8. Review and analyze the current AIDS Surveillance and Education Project (ASEP) Project Paper analysis annexes and recommend changes as appropriate.

II. Background and Program Description

Prior to the commencement of the AIDS Surveillance and Education Project, USAID provided over \$3.5 million to the National AIDS Prevention and Control Program (NAPCP) of the DOH. This assistance was used to fund activities in Metro Manila, Cebu, Olongapo and Angeles City which included training in AIDS counseling, support for an AIDS hotline, general AIDS education, upgrading social hygiene clinics, upgrading regional blood centers, and the completion of a market feasibility study for condoms.

Recognizing the need to do more in HIV/AIDS control and the requirement to support more focused efforts, USAID authorized the ASEP on July 20, 1992. Activities under the ASEP support USAID's program of preventing the rapid increase of HIV/AIDS as articulated in the "Special Objective: Rapid Increase of HIV/AIDS Prevented." Current and new activities under this program are expected to be completed by September 30, 2000. Planned total funding for the program is \$ 20.4 million, with USAID contributing \$15 million.

The overall goal of the SpO is to prevent the rapid increase of HIV/AIDS within the Philippine population by institutionalizing public and private sector mechanisms for:

1. monitoring HIV prevalence and transmission; and
2. encouraging behaviors which reduce individual risk for contracting or transmitting HIV.

To achieve the SpO, USAID and the DOH agreed to the Intermediate Result (IR) "Adoption of STD/HIV/AIDS Prevention Practices by Target Groups Increased." Briefly described below are the activities to achieve this IR:

1. **Surveillance.** USAID support is targeted to establishing an HIV sentinel surveillance system at strategically located geographic sites and population groups. To date, the DOH's Field Epidemiology Training Program (FETP) Unit has established sentinel sites in 10 cities (Quezon City, Pasay City, Cebu City, Davao City, Angeles City, Iloilo City, Cagayan de Oro City, General Santos City, Baguio City, and Zamboanga City). The surveillance system has monitored both female and male commercial sex workers (CSWs), men who have sex with men (MSMs), injecting drug users (IDUs) and patients of STD clinics. Special surveys

have also been conducted among members of the military and truck drivers. A behavioral sentinel surveillance system is also being established in Batangas City and Legazpi City. Funds are being provided via USAID grant to the World Health Organization (WHO) for this component.

2. **Education.** The education component of the program aims to reduce high risk behaviors, thus reducing the transmission of HIV. Local NGOs are being supported to provide community-based information, education and communication (IEC) targeted at groups practicing high risk behaviors, in locations where the sentinel surveillance system has been established. Education and some mass media are based on behavioral research and surveys supported by the ASEP and other projects. Funds for this component are provided through USAID cooperative agreement with PATH.
3. **Blood Banking System.** This activity supports the SpO by providing the framework and the direction for an integrated national response to the problem of an unsafe blood supply. As such, it links logically with USAID's program focus on high risk groups. The formulation of the strategic plan includes a consensus building process to select the best solutions to remedy the problems of safety and inadequacy of blood supply. A local foundation, the New Tropical Medicine Foundation, implements this activity through the PATH Cooperative Agreement.
4. **LGUs/NGOs participation and management of programs.** This activity is aimed at building the capacities of the LGUs to develop and manage effective HIV/AIDS/STD control programs in their cities. This will be achieved by strengthening LGU/NGO STD/HIV/AIDS surveillance and prevention teams in targeted cities through training on surveillance activities, holding of HIV/AIDS fora, building management/planning capabilities and advocacy skills of the local executives and local NGOs through the Phil-Thai technical exchange efforts.

A one page SpO framework is included in Attachment A to provide a summary review.

III. **Statement of Services:**

The members of the assessment/amendment team, shall work under the overall guidance of the Special Objective (AIDS) Team Leader. They should analyze key documents, including: (1) the ASEP Project documents, including the 1996 Results Framework; (2) the DOH Medium Term Plan; (3) FETP surveillance data; (4) various NGO behavioral study data; (5) PATH's annual report. Key documents will be air-shipped to assessment team members prior to their departure for the Philippines and/or provided at the beginning of the assessment process.

The members of the team must interview key DOH, LGU, NGO, WHO and other donor officials. Visits will be made to observe surveillance and IEC activities.

The assessment work will be conducted over a period of three weeks beginning on/about January 13, 1997. The consultants will work a six-day work week without premium pay. The Results Framework amendment activity will be conducted by a Project Analyst over a period of two weeks immediately following the assessment process.

At the beginning of the work period, the team member shall spend two days "team building", interviewing USAID officials, and studying the basic reference documents. During this period, the team must reach common agreement among themselves on specifics of the task and how to proceed. The following period will be spent carrying out the assessment exercise and preparing a consolidated report providing the team's findings and recommendations.

A Revised Results Framework (RF) with appropriate analyses will be submitted by the team leader at the completion of his/her assignment.

A tentative schedule of activities is outlined below.

Tentative Schedule:

January 12	Arrival Manila
January 13	Meetings with USAID officers
January 14	Review of background materials, Team building
January 15-24	Field work
January 27	Debriefing
January 30	Submission to USAID of assessment report
January 31	Departure from Manila (Assessment team members)
February 14	Submission to USAID of amended RF including appropriate analyses (Team Leader)

OPHN may provide some secretarial assistance for the final reports, however, the responsible team members should bring or have on hand a Personal Computer/Word Processor (Word Perfect 5.1) or hire typist(s) to reduce pressure on the USAID staff and equipment.

IV. Team Composition and Detailed Job Description

The team will consist of four technical experts: one Project Analyst as team leader; a surveillance analyst/epidemiologist; an IEC specialist; and an HIV/AIDS organizational policy expert. Following is a description of tasks and responsibilities.

1. Project Analyst:

- a. Act as team leader (TL) and provide overall coordination with USAID, DOH and other members of the team; and oversee that the assessment work is completed including submission to USAID of the Assessment Report.
 - b. Review ASEP Technical, Financial, Economic, Social Soundness and Institutional and Administrative analyses and recommend revisions/updates for the SpO Results Framework.
 - c. Amend the Results Framework for the SpO and prepare other documentation such as analyses mentioned in (b) above needed for Results Framework amendment.
2. Surveillance Analyst/Epidemiologist
 - a. Assess the National HIV surveillance systems and answer the questions listed in the "Surveillance" section.
 3. Information/Education/Communication (IEC) Advisor
 - a. Assess the education component and answer the questions listed in the education section
 4. Organizational/Policy Specialist
 - a. Assess LGU/NGO collaboration and HIV/AIDS organizational policies/administrative management and the voluntary blood donation program assistance and answer questions in the blood banking and organizational policy sections..

The team will address the following questions:

(a) Surveillance:

- (1) What uses have been made of the HIV surveillance data?
- (2) How has the information been used for communication purposes and how has it affected strategic planning in the AIDS program?
- (3) Should the ASEP aim to establish 20 geographic sentinel surveillance sites by 2000, as in the modified design, or should the number of sites be decreased or increased in number?
- (4) What groups should the HIV seroprevalence surveillance target at this stage? Has a system been developed for behavioral surveillance? Are representative groups included in the surveillance?

- (5) Should the six-monthly seroprevalence and behavioral surveillance studies at the DOH/FETP be conducted at the same time? Does this bias results of the behavioral survey?
- (6) Are surveillance results being routinely and clearly communicated to all entities involved in HIV/AIDS control efforts, i.e., within the DOH, to NGOs, and to the donors? Are the data being integrated and are the implications and recommendations being formulated and communicated with end users in mind?
- (7) Is the six-monthly sentinel surveillance too frequent? Should the surveillance be conducted annually?
- (8) Does the FETP-generated survey provide sufficient and usable data?
- (9) Is behavioral surveillance being conducted for tracking purposes only or is the data being utilized in control efforts?
- (10) Are the surveillance data presented in a useable format? Can the format be improved?
- (11) How timely are the delivery of surveillance results?
- (12) How reliable are the data being that requisite sample size for each particular risk group is not obtained. With requisite sample size of each risk group, are data truly representative of the risk group?

b) Education

- (1) To what extent has the AIDS education component advanced the development of a governmental GO and NGO network working on the AIDS epidemic nationwide?
- (2) Which GO and NGO programs appear to have been most effective in producing behavioral changes that reduce the risk of HIV infection?
- (3) Should ASEP limit its IEC focus on selected high risk groups, given the present stage of the epidemic?
- (4) Is the ASEP strategy of utilizing NGOs to provide IEC effective? Should the private sector and/or the GOs be brought in more to assure coverage? If so, how should they be brought into the effort? What roles should they play?

- (5) Is peer education the culturally appropriate model for AIDS education and intervention programs in the Philippines?
- (6) Should ASEP rely more on social marketing in the delivery of IEC?
- (7) Does mass media, aimed at the general population, make sense at this stage?
- (8) Has a system been developed for monitoring and evaluating the quality and impact of strategy activities?
- (9) What is the strategy for the mass media component? Is it epidemiologically sound?
- (10) What impact have past media efforts had on target groups? The general public? Has this been assessed?
- (11) Should mass media target building awareness when there are indications that awareness is already extremely high?
- (12) Should STD syndromic case management strategies and activities continue? Should the activities be expanded?

c) Blood Banking Program

- (1) What has been the impact of the USAID supported Strategic plan for the DOH's National Voluntary Blood donation Program?

(d) Organizational Policy and LGU/NGO participation:

- (1) What are the channels of coordination between the surveillance and education component?
- (2) Are donors effectively coordinating assistance to the NAPCP? Is there duplication of effort and/or areas where too much assistance is being delivered, thus stretching the abilities of the implementing units? Are there important areas where little assistance is being provided?
- (3) Should USAID assistance keep its focus on "high risk" groups in assumed "hot spot" areas? Should the focus be narrowed? Broadened? What are the DOH plans?
- (4) Should the Special Objective address the apparent need to improve STD diagnosis and treatment to groups practicing high risk behaviors, given the importance of classic STDs in HIV transmission? If so, how/what assistance should be provided?

- (5) What role should the the Philippine National AIDS Council (PNAC) play in LGU/NGO activities?
- (6) Has the DOH issued a Departmental Order to establish clear lines of responsibility for implementation of the NAPCP? What are the responsibilities of the LGUs?
- (7) What are the gaps in other support services for STD/AIDS intervention that need to be addressed for overall project impact?
- (8) What role do local government officials play in seroprevalence and behavioral surveillance? What role do the NGOs play? Should they be modified?
- (9) Are other national governmental departments involved in the NAPCP? If not, how can they be involved? What governmental action(s) are needed to get their involvement?
- (10) What mechanisms have been incorporated and need to be done to ensure sustainability of the surveillance system and education activities by the LGUs and NGOs
- (11) How is the Sanitation Code implemented at the local level? Are the provisions promoting or impeding HIV prevention efforts?

V. Reporting Requirements

The following expected outputs will be in the form of written reports:

1. Assessment Report - The team will present to USAID and DOH progress achieved under the program and major findings and recommendations to serve as inputs for the preparation of the Revised Results Framework. The Assessment Report must adequately address all areas specified in Section I, "Objective of the Services". It should include as appropriate:
 - a. Data sheet
 - b. Executive Summary stating the findings, conclusions and recommendations
 - c. Table of Contents
 - d. Body of the Report (which includes a brief project description, the environment in which the project operates, a statement of the methodology used, major findings, conclusions and recommendations, and achievement of project purposes

- e. Annexes
The entire report (exclusive of annexes) should not exceed 50 pages.

Annexes to be attached to the final assessment report include:

1. The scope of work;
 2. A list of persons consulted;
 3. Supplemental background materials useful for a fuller understanding of the report; and
 4. An annotated bibliography of significant research reports/studies consulted.
2. Amended Results Framework with appropriate analysis: Technical, Financial, Economic, Social Soundness and Institutional and Administrative analyses, as appropriate, based on findings of Assessment/Amendment team. The Framework should include:
 1. Glossary of acronyms;
 2. Table of contents;
 3. Introduction;
 4. Body of the SpO Results Framework (which includes a brief SpO background and rationale, implementation plan, cost estimate and financial plan, key assumptions, indicators, measures and targets;) Intermediate Result contribution to the SpO, key assumptions, indicators, measures and targets; activity-level Results key assumptions, measures and targets.)
 5. Annexes - the analyses that need updating from the time the ASEP was prepared.

VI. Method of Payment:

1. Upon submission to and acceptance by USAID of the team work plan and schedule 50%
2. For Assessment team members exclusive of the team leader: Upon submission to and acceptance by USAID of the draft assessment report 40%

	Upon submission to and acceptance by USAID of the final assessment report	10%
3.	For the Team Leader: Upon submission to and acceptance by USAID of the draft amended SpO Results Framework document with analyses as appropriate	40%
	Upon submission to and acceptance by USAID of the final amended SpO RF document with analyses, as appropriate	10%

ANNEX 2: ASSESSMENT PROCEDURES, SITE VISITS AND CONTACTS

- Assessment Procedures

The ASEP Assessment was conducted by a four person team: Dr. James Chin, Professor of Epidemiology, University of California, Berkeley who served as the epidemiologist/surveillance specialist; Dr. Michael Sweat of Johns Hopkins University who served as the team's IEC specialist, Ms. Emelina Almario, a specialist in health finance who served as the organizational specialist, and Dr. Chris Hermann, who served as the team leader. The Assessment was conducted over a three-week period with the first two weeks devoted to data collection and site visits; the third week was spent on preparing drafts and presenting recommendations to several audiences to obtain feedback prior to finalizing the report.

Interviews with DOH officials, WHO staff, PATH's ASEP team, NGO implementing education programs, and local government officials were held in the Manila area during the first week. NGO program activities were visited and reviewed in Pasay City and Quezon City (cities within Metro Manila). Meetings with local government officials and NGOs were then conducted in Angeles City, General Santos City and Cebu City. The Team met with 12 out of 20 on-going NGO programs with site visits to observe field procedures and program activities of 7 NGOs.

On returning to Manila, team members followed-up with key counterparts to obtain additional information, clarify issues and discuss their observations. De-briefings were held separately with other donors providing assistance for STD/HIV programs, with the DOH and with USAID.

- NGO Programs Visited

DKT/ASEP Office
Kabalikat Drop In Center, Quezon City
ReachOut - Quezon City and Pasay City
League of Angeles City Entertainers and Managers (LACEM), Angeles City
ReachOut - Angeles City
Mahintana/Dole Office - General Santos City
Community Health and Development, Inc. (COMDEV) - General Santos City
University of Southern Philippines Foundation (USPF) - Cebu City
Bidlisiw - Cebu City
Fellowship for Organizing Endeavors (FORGE) - Cebu City
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ANNEX 3: FINDINGS AND RECOMMENDATIONS FOR SURVEILLANCE FROM THE 1995 MID-TERM EVALUATION

Key Findings:

1. HSS findings during 1993 and 1994 indicate that the prevalence of HIV continues to be very low among all of the target high HIV risk "groups".
2. The requisite sample size of 300 has been attained for the registered female commercial sex workers, but the sample size for most of the other target groups were relatively low.
3. Relatively high sero-positive rates for syphilis (5-12%) were found in several of the risk groups included in HSS.
4. The highest condom usage rates were reported by the registered FCSWs while reported condom use was very low in most of the other groups.

Key Recommendations:

1. Given the current low prevalence, the high-risk groups selected for HSS remain the most appropriate target groups for public health surveillance.
2. The initial target of 30 geographic sites by EOP is not practical or needed at this stage of the epidemic. If HIV prevalence does begin to reach 2 to 3% in one or more of the high risk "groups" in 1995, then plans for increasing the number of geographic sites for HSS from the current six to a total of ten or twelve should be considered in 1996.
3. The FETP should develop alternative methods and time frames for collecting blood specimens for HIV surveillance from "groups" such as men who have sex with men (MSM), male STD patients, and injecting drug users (IDUs). NGOs who work with the above risk "groups" should be more actively involved in obtaining access to these groups for collection of surveillance data.
4. The continued emphasis directed to CSWs whose clients are mostly foreign males is unwarranted. Any "explosion" of HIV infections, if and when it may occur, will be more likely in CSWs who have the highest average number of sexual partners and who have low condom use rates. HSS should focus priority on CSWs with these characteristics and assure that they are included in the HSS.
5. In coordination with the AIDS/STD Unit, FETP, PATH, and major NGOs should collectively decide what behavioral data are needed to evaluate the overall effectiveness of ASEP educational activities. FETP should support the development of standard questions for the routine collection of behavioral data.
6. DOH should be permitted to contract with a private or academic agency for the development and implementation of behavioral surveillance, if needed.
7. NGOs implementing the ASEP education component should not be given the primary responsibility of collecting the data for the behavioral surveillance, but should be asked to assist data collectors in gaining access to the groups they work

with. Each NGO should continue to gather additional behavioral data needed to implement, monitor and evaluate its sub-project.

8. The collection of the behavioral data should be coordinated with HSS but probably should be carried out at a different time and with different staff. For example, HSS can be scheduled at a site from January to February and from July to August and the behavioral surveillance survey (BSS) from April to May and October to November. Behavioral data can then be used to evaluate and validate the more limited behavioral data collected in HSS.
9. ASEP should not develop a comprehensive STD surveillance system at this time. No clear cut guidelines as to what STDs should be included and what clinical and laboratory tests should be used in STD surveillance have been developed. However, blood samples collected for HSS should continue to be routinely tested for syphilis. Data on syphilis prevalence provide another general measurement of risk behavior.
10. When high syphilis rates (>10%) for a given risk "group" are identified, more aggressive control measures such as expanded syphilis testing and treatment should be carried out.
11. Instead of using detected HIV positive cases or reported AIDS cases to target areas or "groups" for increased public health intervention, behavioral data collected in HSS rounds should be used to step-up public health and NGO activities in those areas and "groups" with the highest levels of risk behavior.
12. DOH should develop resources to assure that HSS will not be discontinued in some geographic sites because of inadequate LGU support.

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ANNEX 4: STAGES OF CHANGE MODEL (PROCHASKA)

Pre-contemplative

↓ ***(knowledge)***

Contemplative

↓ ***(susceptibility (risk & severity perception))***

Ready for Change

↓ ***(expected outcomes, skills/efficacy, impact soc network, norms, commodity/services access)***

Behavior Change

↓ ***(social support)***

Sustained Behavior Change

Interventions specific to Constructs

- Knowledge -- education
- Perceived Severity - education, exposure to PWA/PWHIV
- Risk Perception - education, personal experiences & friends experiences
- Skills/Efficacy - training, experimentation
- Impact on social network - use PWA's similar to target group, peer education
- Norms - social marketing, peer education
- Commodity & services access - condom access, HIV testing services, etc...
- Social support - support groups, community organization, environmental interventions

SS

ANNEX 5: STD/HIV Research Topics

- (1) A study of child sex workers to identify the scope and distribution of the problem. Research should also be conducted to develop appropriate intervention approaches for young girls working in the sex industry to reduce the risk of sexually transmitted disease and HIV infection, and physical and emotional abuse. Such research should attempt to identify the likely social factors promoting child sex work, and the optimal ways to liberate children from sex work. Rapid ethnographic survey approaches could be utilized.
- (2) Evaluation of IEC materials to identify their appropriateness and effectiveness in promoting HIV risk reduction among the target groups. This could be accomplished through focus group discussions, and individual in-depth interviews.
- (3) Evaluation of HIV harm reduction methodologies (especially needle exchange) among IDUs. The primary research question is whether needle exchange results in lower rates of needle sharing and associated HIV transmission.
- (4) A cross-sectional study of male sexual behavior and condom use in selected cities in the Philippines. This would be useful in estimating the number of men who regularly have sex with CSWs and the rate of condom use. Such data would be very helpful in determining the potential for an "explosive" epidemic of HIV in the general population of the Philippines, and would help to establish baseline rates of risk behavior for intervention projects.
- (5) Research investigating the level of antibiotic resistance among prevalent sexually transmitted pathogens. These data would be of great help in evaluating the current treatment regimen for STD infection.
- (6) Research on structural and environment interventions -- such as formative research for a 100% condom intervention. This could be accomplished via an ethnographic study of sex establishments with individual interviews with sex workers, managers, owners, and public health officials. A pilot project could then be developed to examine the feasibility and efficacy of such a program.
- (7) An opinion survey of the acceptability of various HIV and STD prevention methodologies among the general population. This might be included in the next DHS.
- (8) Operational research on the potential to integrate HIV and STD prevention into other USAID supported projects, especially family planning projects. Research questions include: (1) development of an effective risk assessment tool to assist FP counselors in targeting some clients for condom use, (2) how to reach men for HIV/STD counseling via the family planning system, and (3) operational issues related to changes in provision of services.
- (9) Cost-benefit analysis of provision of STD drugs, and perhaps targeted mass treatment for STD (especially syphilis). This research would examine how provision of STD diagnosis and treatment of high risk individuals would result in overall reductions in the population level of STD, and the reduction in the societal costs of STD outcomes -- such

as drug treatment costs and rates of congenital syphilis. Similar studies of the potential for targeted mass treatment for syphilis would be helpful. This research could model the costs and benefits of presumptively treating (without diagnosis) all members of risk groups during a single time interval. The benefits of a mass treatment are that you can avoid reinfection problems, avoid the cost of diagnosis, and assure a reduction in overall syphilis prevalence. Such a system would be triggered by high rates of STD identified in sentinel surveillance studies. This might be feasible in the Philippines, and would potentially help to address the untreated syphilis problem. There would also need to be an acceptability study of mass treatment among the target populations.

- (10) A study that would determine the distribution of target groups across the "stages of change continuum" (as described by Prochaska - refer to Annex 4). This research would help to determine which specific intervention activities are needed for specific populations, and would help to establish reasonable evaluation baselines and goals by population target group. Staging can be accomplished through the use of a 4-item scale for each behavior of interest. This could be included in the NGOs evaluation surveys.
- (11) A follow up study of the actual rate of infectious syphilis among those persons who are identified as "syphilis positive" in the sentinel surveillance sites. This would help to determine the actual level of infectious syphilis that exists in the country, which the current system does not fully indicate.